ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	CCS	Trauma/Orthopaedic Theatre	Minor	Personal Information redacted by the USI	FA	29/08/2014	Brigeen Kelly
		Craigavon Area Hospital	FSS	1 North Cardiology	Minor		FA	29/08/2014	Gerard White
		Craigavon Area Hospital	IMWH	2 West Maternity Post Natal	Insignificant		FA	23/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	2 East Midwifery Led Unit	Moderate		INREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	2 North Resp/Medical	Minor		FA	02/09/2014	Sandra Burns
		Daisy Hill Hospital	MUC	Stroke / Rehab	Minor		FA	09/09/2014	Sandra Burns
		Daisy Hill Hospital	MUC	Stroke / Rehab	Minor		FA	03/10/2014	Anne Harris
		Craigavon Area Hospital	MUC	MAU	Minor		INREV	18/09/2014	Sandra Burns
		Craigavon Area Hospital	SEC	Orthopaedic Ward	Moderate		FA	03/09/2014	Connie Connolly
		Craigavon Area Hospital	MUC	MAU	Minor		AWAREV		

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ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Daisy Hill Hospital	MUC	ED Majors	Major	Personal Information redacted by the USI	INREV	15/09/2014	Paul Smyth
		Craigavon Area Hospital	MUC	2 North Haematology	Minor		FA	05/09/2014	Sandra Burns
		Daisy Hill Hospital	MUC	Female Medical, Level 5	Minor		FA	01/09/2014	Sandra Burns
		Daisy Hill Hospital	CCS	Theatre	Minor		FA	01/09/2014	Brigeen Kelly
		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Minor		INREV	02/09/2014	Mrs Patricia Kingsnorth
		Daisy Hill Hospital	MUC	General Male Medical, Level 5	Minor		AWAREV		
		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Moderate		FA	02/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	1 North Cardiology	Insignificant		INREV	09/09/2014	Kay Carroll

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ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Daisy Hill Hospital	MUC	Stroke / Rehab	Minor	Personal Information redacted by the USI	FA	09/09/2014	Sandra Burns
		Daisy Hill Hospital	MUC	General Male Medical, Level 5	Minor		AWAREV		
		Craigavon Area Hospital	IMWH	2 West Maternity Post Natal	Moderate		INREV		Mrs Patricia Kingsnorth
		Daisy Hill Hospital	MUC	Stroke / Rehab	Minor		FA	11/09/2014	Anne Harris
		Craigavon Area Hospital	MUC	1 South Medical	Minor		FA	11/09/2014	Sandra Burns
		Craigavon Area Hospital	FSS	4 North	Moderate		FA	02/09/2014	Hammond Coppinger
		Craigavon Area Hospital	FSS	4 North	Insignificant		FA	02/09/2014	Hammond Coppinger
		Craigavon Area Hospital	SEC	4 North	Moderate		INREV	03/09/2014	Connie Connolly

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ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	SEC	3 South	Minor	Personal Information redacted by the USI	FA	03/09/2014	Connie Connolly
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Major		INREV		Mrs Patricia Kingsnorth
		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Moderate		FA	02/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	MAU	Minor		AWAREV		
		Daisy Hill Hospital	MUC	Stroke / Rehab	Minor		AWAREV		
		Daisy Hill Hospital	MUC	Stroke / Rehab	Minor		AWAREV		
		Craigavon Area Hospital	CCS	Theatre	Insignificant		INREV	23/09/2014	Brigeen Kelly
		Craigavon Area Hospital	IMWH	2 West Maternity Post Natal	Minor		FA	01/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	SEC	3 South	Minor		FA	03/09/2014	Connie Connolly

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ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Daisy Hill Hospital	SEC	Female Surgical/Gynae	Moderate	Personal Information redacted by the USI	NREV		Sandra Burns
		Daisy Hill Hospital	MUC	ED Resus	Minor		FA	15/09/2014	Paul Smyth
		Daisy Hill Hospital	FSS	Corridor/Stairs	Insignificant		FA	01/09/2014	Dorothy Morton
		Craigavon Area Hospital	CSCG	ED Majors	Minor		AWAREV		
		Lurgan Hospital	CCS	Breast Screening Unit	Minor		NREV	19/09/2014	Jeanette Robinson
		Craigavon Area Hospital	FSS	Basement	Minor		FA	16/09/2014	Gerard White
		Craigavon Area Hospital	MUC	MAU	Insignificant		FA	30/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	ED Minors	Moderate		FA	15/09/2014	Paul Smyth

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ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	IMWH	Day Procedure/Day Surgery Unit	Minor	Personal Information redacted by the USI	INREV		Mrs Patricia Kingsnorth
		Daisy Hill Hospital	MUC	Day Clinical Centre	Minor		FA	09/09/2014	Sandra Burns
		Craigavon Area Hospital	IMWH	2 West Maternity Post Natal	Minor		INREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	X-ray Dept (Radiology)	Minor		FA	08/09/2014	DeniseE Newell
		Armagh Community Hospital	MUC	Car Park/Grounds	Moderate		FA	15/09/2014	Paul Smyth
		Craigavon Area Hospital	FSS	Switchboard	Minor		FA	05/09/2014	Kate Corley

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ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	IMWH	1 West Gynae	Minor	Personal Information redacted by the USI	INREV	16/09/2014	Mrs Patricia Kingsnorth
		Daisy Hill Hospital	FSS	ED Majors	Minor		FA	29/09/2014	Dorothy Morton
		Daisy Hill Hospital	FSS	Boiler House	Minor		FA	01/09/2014	Dorothy Morton
		Craigavon Area Hospital	FSS	Switchboard	Insignificant		FA	05/09/2014	Kate Corley
		Craigavon Area Hospital	CCS	Theatre	Minor		INREV		Brigeen Kelly
		Craigavon Area Hospital	SEC	4 North	Minor		FA	03/09/2014	Connie Connolly
		Daisy Hill Hospital	SEC	Male Surgical/HDU	Insignificant		FA	03/09/2014	Connie Connolly
		Craigavon Area Hospital	CCS	ICU (HDU)	Insignificant		FA	02/09/2014	Brigeen Kelly
		Craigavon Area Hospital	MUC	2 South Medical	Minor		FA	05/09/2014	Sandra Burns
		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Minor		FA	26/09/2014	Mrs Patricia Kingsnorth
		Daisy Hill Hospital	IMWH	Maternity Ward	Minor		INREV	25/09/2014	Mrs Patricia Kingsnorth
		Daisy Hill Hospital	FSS	Entrance/Exit	Minor		FA	29/09/2014	Dorothy Morton

ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	MUC	ED Minors	Moderate	Personal Information redacted by the USI	FA	15/09/2014	Paul Smyth
		Craigavon Area Hospital	SEC	3 South	Moderate		FA	03/09/2014	Connie Connolly
		Craigavon Area Hospital	IMWH	1 West Gynae	Insignificant		INREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	1 West Gynae	Minor		INREV	03/09/2014	Valerie Webb
		Daisy Hill Hospital	FSS	Rehabilitation, Level 4	Moderate		FA	29/09/2014	Dorothy Morton
		Craigavon Area Hospital	SEC	Day Procedure/Day Surgery Unit	Insignificant		AWAREV	25/09/2014	Sharon Glenny
		Daisy Hill Hospital	SEC	Male Surgical/HDU	Minor		FA	03/09/2014	Connie Connolly
		Craigavon Area Hospital	CCS	ICU (HDU)	Insignificant		INREV	03/09/2014	Helen McGarry
		Craigavon Area Hospital	FSS	ED Majors	Minor		FA	12/09/2014	Ciera Campbell
		Daisy Hill Hospital	MUC	Stroke / Rehab	Minor		FA	09/09/2014	Sandra Burns

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Personal Information redacted by the USI		Craigavon Area Hospital	MUC	2 North Haematology	Insignificant	Personal Information redacted by the USI	FA	09/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	2 South Medical	Minor		INREV	05/09/2014	Maria Muldoon
		Craigavon Area Hospital	CCS	Breast Clinic	Minor		INREV		Margaret Holland
		Craigavon Area Hospital	CCS	ICU (HDU)	Minor		FA	04/09/2014	Brigeen Kelly
		Craigavon Area Hospital	CCS	X-ray Dept (Radiology)	Minor		INREV		Ursula McSherry
		Craigavon Area Hospital	SEC	3 South	Insignificant		FA	04/09/2014	Connie Connolly
		Craigavon Area Hospital	SEC	4 North	Minor		FA	03/09/2014	Connie Connolly
		Craigavon Area Hospital	FSS	Basement	Minor		FA	12/09/2014	Ciera Campbell

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ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	IMWH	1 West Gynae	Minor	Personal Information redacted by the USI	INREV	16/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	2 South Medical	Minor		FA	05/09/2014	Sandra Burns
		Craigavon Area Hospital	IMWH	Early Pregnancy Problem Clinic	Moderate		INREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	CCS	Oncology Clinic, Mandeville Unit	Moderate		INREV	12/09/2014	Theresa Clarke
		Craigavon Area Hospital	MUC	ED Majors	Moderate		FA	15/09/2014	Paul Smyth
		Craigavon Area Hospital	SEC	CEAW	Minor		INREV	12/09/2014	Nichola McClenaghan

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Personal Information redacted by the USI		Daisy Hill Hospital	MUC	Day Clinical Centre	Minor	Personal Information redacted by the USI	NREV	09/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	ED Clinical Decisions Unit	Major		A	15/09/2014	Paul Smyth
		Armagh Community Hospital	MUC	Minor Injuries Unit	Minor		NREV	02/10/2014	Paul Smyth
		Craigavon Area Hospital	FSS	ED Majors	Minor		A	12/09/2014	Ciera Campbell
		Craigavon Area Hospital	IMWH	1 West Gynae	Minor		NREV	23/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	MAU	Minor		A	18/09/2014	Sandra Burns
		Craigavon Area Hospital	FSS	MAU	Insignificant		A	12/09/2014	Ciera Campbell

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Personal Information redacted by the USI		Craigavon Area Hospital	SEC	4 North	Minor	Personal Information redacted by the USI	INREV	09/09/2014	Connie Connolly
		Craigavon Area Hospital	CCS	Day Procedure/Day Surgery Unit	Insignificant		AWAREV		
		Daisy Hill Hospital	CCS	Theatre	Minor		INREV	23/09/2014	Brigeen Kelly
		Craigavon Area Hospital	CCS	ECT Suite	Minor		INREV		Brigeen Kelly
		Craigavon Area Hospital	MUC	ED Clinical Decisions Unit	Insignificant		FA	18/09/2014	Paul Kerr
		Craigavon Area Hospital	IMWH	Early Pregnancy Problem Clinic	Minor		FA	19/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	MAU	Insignificant		FA	01/10/2014	Sandra Burns
		Daisy Hill Hospital	MUC	Stroke / Rehab	Minor		INREV		Anne Harris

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Personal Information redacted by the USI		Craigavon Area Hospital	CCS	Theatre	Insignificant	Personal Information redacted by the USI	INREV	08/09/2014	Brigeen Kelly
		Craigavon Area Hospital	SEC	4 North	Moderate		INREV	09/09/2014	Connie Connolly
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		FA	24/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Moderate		INREV	24/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	SEC	4 South	Minor		INREV	09/09/2014	Connie Connolly
		Craigavon Area Hospital	CCS	ICU (HDU)	Insignificant		FA	10/09/2014	Brigeen Kelly
		Craigavon Area Hospital	MUC	ED Majors	Moderate		FA	15/09/2014	Paul Smyth
		Craigavon Area Hospital	MUC	MAU	Minor		FA	30/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	2 South Stroke	Insignificant		FA	08/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	2 South Stroke	Minor		FA	08/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	2 South Stroke	Minor		FA	08/09/2014	Sandra Burns

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Personal Information redacted by the USI		Craigavon Area Hospital	MUC	2 South Stroke	Insignificant	Personal Information redacted by the USI	FA	08/09/2014	Sandra Burns
		Craigavon Area Hospital	FSS	Switchboard	Minor		FA	10/09/2014	Kate Corley
		Craigavon Area Hospital	SEC	3 South	Minor		FA	09/09/2014	Connie Connolly
		Craigavon Area Hospital	SEC	3 South	Moderate		NREV	09/09/2014	Connie Connolly
		Craigavon Area Hospital	MUC	Emergency Department	Minor		FA	15/09/2014	Paul Smyth
		Daisy Hill Hospital	SEC	Male Surgical/HDU	Minor		FA	09/09/2014	Connie Connolly
		Craigavon Area Hospital	MUC	2 North Resp/Medical	Minor		FA	08/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	1 South Medical	Insignificant		FA	11/09/2014	Sandra Burns
		Craigavon Area Hospital	CCS	Theatre	Minor		NREV		Marie Wilson
		Craigavon Area Hospital	FSS	Orthopaedic Ward	Minor		NREV	09/09/2014	Kate Corley
		Daisy Hill Hospital	IMWH	Maternity Ward	Moderate		NREV	23/09/2014	Mrs Patricia Kingsnorth

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Personal Information redacted by the USI		Craigavon Area Hospital	CCS	Oncology Clinic, Mandeville Unit	Insignificant	Personal Information redacted by the USI	AWAREV		
		Craigavon Area Hospital	MUC	ED Majors	Minor		FA	15/09/2014	Paul Smyth
		Craigavon Area Hospital	IMWH	Admissions/ Assessment Unit	Moderate		INREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	1 South Medical	Minor		FA	11/09/2014	Sandra Burns
		Craigavon Area Hospital	IMWH	1 West Gynae	Minor		FA	19/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	SEC	4 North	Minor		INREV	09/09/2014	Connie Connolly
		Craigavon Area Hospital	MUC	ED Clinical Decisions Unit	Moderate		FA	15/09/2014	Paul Smyth
		Craigavon Area Hospital	SEC	Trauma Ward	Minor		FA	09/09/2014	Rhonda Hunter
		Daisy Hill Hospital	FSS	General Male Medical, Level 5	Minor		FA	29/09/2014	Dorothy Morton

ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor	Personal Information redacted by the USI	INREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	PHARM	Pharmacy Stores / Distribution	Minor		AWAREV		
		Craigavon Area Hospital	CCS	ED X-ray	Moderate		INREV		Andrene Graham
		Daisy Hill Hospital	MUC	ED Majors	Moderate		INREV	15/09/2014	Paul Smyth
		Craigavon Area Hospital	SEC	Trauma Ward	Minor		FA	11/09/2014	Connie Connolly
		Daisy Hill Hospital	MUC	ED Majors	Moderate		INREV	15/09/2014	Paul Smyth
		Daisy Hill Hospital	CCS	ED X-ray	Minor		FA	09/09/2014	Liz McWilliams

ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	SEC	3 South	Minor	Personal Information redacted by the USI	FA	10/09/2014	Connie Connolly
		Craigavon Area Hospital	CCS	Theatre	Insignificant		FA	11/09/2014	Brigeen Kelly
		Craigavon Area Hospital	CCS	ED Resus	Minor		FA	11/09/2014	Brigeen Kelly
		Craigavon Area Hospital	MUC	ED Majors	Moderate		FA	16/09/2014	Paul Smyth
		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Moderate		FA	19/09/2014	Mrs Patricia Kingsnorth
		Daisy Hill Hospital	MUC	General Male Medical, Level 5	Minor		AWAREV		
		Craigavon Area Hospital	SEC	3 South	Minor		FA	11/09/2014	Connie Connolly
		Craigavon Area Hospital	CCS	ICU (HDU)	Insignificant		FA	11/09/2014	Brigeen Kelly
		Craigavon Area Hospital	IMWH	1 West Gynae	Minor		NREV		Mrs Patricia Kingsnorth

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Personal Information redacted by the USI		Daisy Hill Hospital	IMWH	Maternity Ward	Insignificant	Personal Information redacted by the USI	INREV	23/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	1 West Gynae	Minor		INREV		Mrs Patricia Kingsnorth
		Daisy Hill Hospital	IMWH	Maternity Ward	Insignificant		FA	22/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	SEC	Day Procedure/Day Surgery Unit	Insignificant		AWAREV	25/09/2014	Sharon Glenny
		Craigavon Area Hospital	SEC	3 South	Insignificant		FA	10/09/2014	Connie Connolly
		Daisy Hill Hospital	IMWH	Theatre	Minor		INREV	23/09/2014	Mrs Patricia Kingsnorth
		Daisy Hill Hospital	FSS	Entrance/Exit	Minor		FA	29/09/2014	Dorothy Morton
		Daisy Hill Hospital	FSS	Reception/ Waiting Area	Minor		FA	29/09/2014	Dorothy Morton

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Personal Information redacted by the USI		Craigavon Area Hospital	MUC	2 North Haematology	Minor	Personal Information redacted by the USI	A	11/09/2014	Kay Carroll
		Craigavon Area Hospital	CCS	Recovery Unit	Insignificant		A	12/09/2014	EmmaJane Kearney
		Craigavon Area Hospital	FSS	ED Majors	Minor		A	25/09/2014	Ciera Campbell
		Craigavon Area Hospital	CCS	Corridor/Stairs	Minor		NREV	19/09/2014	Brigeen Kelly
		Daisy Hill Hospital	IMWH	Maternity Ward	Minor		A	30/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	Gynae Clinic	Minor		NREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	Antenatal Clinic	Minor		NREV	26/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	1 West Gynae	Moderate		NREV	16/09/2014	Mrs Patricia Kingsnorth

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Personal Information redacted by the USI		Craigavon Area Hospital	IMWH	1 West Gynae	Minor	Personal Information redacted by the USI	INREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	Antenatal Clinic	Minor		INREV	26/09/2014	Mrs Patricia Kingsnorth
		Daisy Hill Hospital	CCS	Male Surgical/HDU	Moderate		AWAREV	12/09/2014	Brian Magee
		Craigavon Area Hospital	MUC	MAU	Minor		FA	30/09/2014	Sandra Burns
		Craigavon Area Hospital	CCS	Oncology Clinic, Mandeville Unit	Minor		AWAREV		
		Craigavon Area Hospital	FSS	2 East Midwifery Led Unit	Minor		AWAREV		
		Craigavon Area Hospital	SEC	Orthopaedic Ward	Moderate		INREV	15/09/2014	Connie Connolly
		Craigavon Area Hospital	FSS	Basement	Minor		FA	12/09/2014	Gerard White

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Personal Information redacted by the USI		Craigavon Area Hospital	SEC	4 South	Minor	Personal Information redacted by the USI	FA	12/09/2014	Connie Connolly
		Craigavon Area Hospital	MUC	1 North Cardiology	Insignificant		INREV	17/09/2014	Kay Carroll
		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Minor		FA	22/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	CCS	Trauma/Orthopaedic Theatre	Minor		FA	17/09/2014	Julie O'Hagan
		Craigavon Area Hospital	SEC	4 North	Insignificant		FA	22/09/2014	Connie Connolly
		Craigavon Area Hospital	MUC	1 North Cardiology	Insignificant		INREV	17/09/2014	Kay Carroll
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		INREV		Mrs Patricia Kingsnorth

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Personal Information redacted by the USI		Daisy Hill Hospital	MUC	Emergency Department	Moderate	Personal Information redacted by the USI	INREV	15/09/2014	Paul Smyth
		Lurgan Hospital	CCS	Breast Screening Unit	Moderate		INREV	19/09/2014	Jeanette Robinson
		Craigavon Area Hospital	SEC	Trauma Ward	Minor		INREV	15/09/2014	Connie Connolly
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		FA	16/09/2014	Mrs Patricia Kingsnorth
		Daisy Hill Hospital	MUC	Male Surgical/HDU	Major		AWAREV		Mrs Lucia Cunningham
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		INREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	SEC	Orthopaedic Ward	Moderate		INREV	15/09/2014	Connie Connolly
		Craigavon Area Hospital	MUC	MAU	Minor		AWAREV		
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		FA	17/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	CCS	Trauma/Orthopaedic Theatre	Minor		INREV	25/09/2014	Julie O'Hagan

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Personal Information redacted by the USI		Daisy Hill Hospital	MUC	Female Medical, Level 5	Moderate	Personal Information redacted by the USI	INREV		Sr Nicola McKnight
		Daisy Hill Hospital	MUC	Emergency Department	Minor		INREV	15/09/2014	Paul Smyth
		Daisy Hill Hospital	MUC	ED Majors	Moderate		INREV	15/09/2014	Paul Smyth
		Craigavon Area Hospital	MUC	ED Minors	Moderate		INREV		Paul Smyth
		Craigavon Area Hospital	SEC	Trauma Ward	Minor		FA	15/09/2014	Connie Connolly
		Craigavon Area Hospital	MUC	2 South Medical	Minor		AWAREV		
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		INREV	02/10/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		INREV	02/10/2014	Mrs Patricia Kingsnorth

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ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	MUC	MAU	Insignificant	Personal Information redacted by the USI	FA	01/10/2014	Sandra Burns
		Craigavon Area Hospital	MUC	1 South Medical	Minor		FA	18/09/2014	Sandra Burns
		Craigavon Area Hospital	SEC	Orthopaedic Ward	Moderate		INREV	15/09/2014	Connie Connolly
		Craigavon Area Hospital	SEC	4 South	Moderate		FA	15/09/2014	Tracey McGuigan
		Craigavon Area Hospital	IMWH	2 West Maternity Post Natal	Minor		INREV	24/09/2014	Mrs Patricia Kingsnorth
		Daisy Hill Hospital	SEC	Male Surgical/HDU	Minor		FA	15/09/2014	Connie Connolly
		Daisy Hill Hospital	FSS	ED Majors	Minor		FA	29/09/2014	Dorothy Morton
		Craigavon Area Hospital	MUC	2 North Resp/Medical	Minor		FA	16/09/2014	Sandra Burns
		Craigavon Area Hospital	FSS	4 North	Minor		AWAREV	15/09/2014	Anita Carroll
		Craigavon Area Hospital	MUC	2 South Stroke	Minor		FA	23/09/2014	Sandra Burns
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Insignificant		INREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		FA	16/09/2014	Mrs Patricia Kingsnorth

ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Daisy Hill Hospital	SEC	Female Surgical/Gynae	Minor	Personal Information redacted by the USI	FA	16/09/2014	Connie Connolly
		Craigavon Area Hospital	CCS	ICU (HDU)	Insignificant		FA	22/09/2014	Helen McGarry
		Craigavon Area Hospital	MUC	MAU	Minor		FA	01/10/2014	Sandra Burns
		Armagh Community Hospital	MUC	Minor Injuries Unit	Moderate		INREV	16/09/2014	Paul Smyth
		Craigavon Area Hospital	CCS	Day Procedure/Day Surgery Unit	Minor		INREV		Marie Wilson
		Craigavon Area Hospital	FSS	1 South Medical	Minor		FA	30/09/2014	Sandra Burns
		Craigavon Area Hospital	CCS	Trauma/Orthopaedic Theatre	Minor		FA	17/09/2014	Brigeen Kelly

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Personal Information redacted by the USI		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Moderate	Personal Information redacted by the USI	INREV	24/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	2 Medical	Minor		AWAREV		
		Daisy Hill Hospital	FSS	Kitchen	Moderate		INREV	23/09/2014	Dorothy Morton
		Craigavon Area Hospital	MUC	1 South Medical	Insignificant		FA	30/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	2 South Medical	Minor		FA	17/09/2014	Sandra Burns
		Daisy Hill Hospital	SEC	Female Surgical/Gynae	Minor		FA	16/09/2014	Connie Connolly
		Craigavon Area Hospital	SEC	4 South	Minor		INREV	16/09/2014	Tracey McGuigan
		Craigavon Area Hospital	SEC	3 South	Minor		FA	23/09/2014	Connie Connolly

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ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	MUC	Emergency Department	Moderate	Personal Information redacted by the USI	AWAREV		
		Craigavon Area Hospital	SEC	4 South	Minor		INREV	18/09/2014	Tracey McGuigan
		Craigavon Area Hospital	PHARM	Pharmacy Dispensary	Insignificant		AWAREV		
		Craigavon Area Hospital	IMWH	1 West Gynae	Minor		INREV	26/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	FSS	Switchboard	Minor		FA	19/09/2014	Kate Corley
		Craigavon Area Hospital	CCS	Bio-chemistry Lab	Insignificant		AWAREV		
		Craigavon Area Hospital	MUC	1 South Medical	Insignificant		FA	18/09/2014	Sandra Burns
		Craigavon Area Hospital	CCS	Day Procedure/Day Surgery Unit	Minor		INREV		Marie Wilson
		Craigavon Area Hospital	CCS	Day Procedure/Day Surgery Unit	Minor		AWAREV		

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ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Daisy Hill Hospital	MUC	Female Medical, Level 5	Minor	Personal Information redacted by the USI	FA	18/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	ED Resus	Major		INREV		Paul Smyth
		Daisy Hill Hospital	IMWH	Female Surgical/Gynae	Minor		FA	19/09/2014	Mrs Patricia Kingsnorth
		Daisy Hill Hospital	MUC	Female Medical, Level 5	Insignificant		FA	18/09/2014	Sandra Burns
		Daisy Hill Hospital	FSS	General Male Medical, Level 5	Minor		FA	23/09/2014	Dorothy Morton
		Daisy Hill Hospital	SEC	Female Surgical/Gynae	Minor		FA	22/09/2014	Connie Connolly
		Daisy Hill Hospital	MUC	Female Medical, Level 5	Moderate		FA	26/09/2014	Sandra Burns
		Craigavon Area Hospital	IMWH	Antenatal Clinic	Moderate		INREV		Mrs Patricia Kingsnorth

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ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	SEC	4 South	Minor	Personal Information redacted by the USI	FA	22/09/2014	Connie Connolly
		Craigavon Area Hospital	CCS	Cardiology Clinic	Minor		AWAREV		
		Craigavon Area Hospital	MUC	1 North Cardiology	Minor		AWAREV		
		Craigavon Area Hospital	CCS	Breast Screening Unit	Moderate		INREV		Margaret Holland
		Craigavon Area Hospital	CCS	ICU (HDU)	Minor		FA	22/09/2014	Helen McGarry
		Craigavon Area Hospital	IMWH	1 West Gynae	Minor		INREV	26/09/2014	Mrs Patricia Kingsnorth
		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Minor		INREV	22/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	FSS	CEAW	Minor		FA	22/09/2014	Kate Corley

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ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	CCS	Day Procedure/Day Surgery Unit	Minor	Personal Information redacted by the USI	INREV	22/09/2014	Marie Wilson
		Craigavon Area Hospital	MUC	MAU	Minor		INREV	18/09/2014	Sandra Burns
		Craigavon Area Hospital	CCS	Theatre	Insignificant		FA	19/09/2014	Brigeen Kelly
		Community	IMWH	Kilkeel Health Centre	Minor		FA	26/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	CCS	Day Procedure/Day Surgery Unit	Insignificant		AWAREV		
		Craigavon Area Hospital	CCS	Theatre	Insignificant		INREV	23/09/2014	Brigeen Kelly
		Craigavon Area Hospital	IMWH	Gynae Clinic	Minor		INREV	25/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	Gynae Clinic	Minor		FA	23/09/2014	Mrs Patricia Kingsnorth

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Personal Information redacted by the USI		Craigavon Area Hospital	MUC	MAU	Minor	Personal Information redacted by the USI	FA	01/10/2014	Sandra Burns
		South Tyrone Hospital	IMWH	Day Procedure/Day Surgery Unit	Minor		INREV	25/09/2014	Patricia McStay
		Craigavon Area Hospital	MUC	ED Clinical Decisions Unit	Major		AWAREV		
		Craigavon Area Hospital	CCS	Oncology Clinic, Mandeville Unit	Minor		AWAREV		
		Craigavon Area Hospital	MUC	Ramone Building	Minor		AWAREV		
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		INREV	02/10/2014	Mrs Patricia Kingsnorth

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Personal Information redacted by the USI		Craigavon Area Hospital	SEC	Day Procedure/Day Surgery Unit	Minor	Personal Information redacted by the USI	AWAREV	25/09/2014	Sharon Glenny
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		FA	22/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	1 South Medical	Minor		FA	30/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	Emergency Department	Moderate		AWAREV		
		Craigavon Area Hospital	MUC	Emergency Department	Moderate		FA	24/09/2014	Paul Smyth
		Daisy Hill Hospital	SEC	Male Surgical/HDU	Moderate		NREV	26/09/2014	Connie Connolly
		Craigavon Area Hospital	MUC	1 South Medical	Minor		FA	30/09/2014	Sandra Burns
		Craigavon Area Hospital	SEC	Day Procedure/Day Surgery Unit	Insignificant		AWAREV	25/09/2014	Sharon Glenny
		Craigavon Area Hospital	MUC	ED Majors	Moderate		FA	02/10/2014	Paul Smyth

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Personal Information redacted by the USI		Craigavon Area Hospital	MUC	MAU	Insignificant	Personal Information redacted by the USI	FA	01/10/2014	Sandra Burns
		Craigavon Area Hospital	MUC	MAU	Minor		FA	01/10/2014	Sandra Burns
		Craigavon Area Hospital	FSS	ED Majors	Minor		AWAREV		
		Craigavon Area Hospital	FSS	ED Majors	Insignificant		AWAREV		
		Craigavon Area Hospital	CCS	Bio-chemistry Lab	Minor		AWAREV		
		Craigavon Area Hospital	CCS	4 North	Insignificant		AWAREV		
		Craigavon Area Hospital	IMWH	1 West Gynae	Minor		NREV		Mrs Patricia Kingsnorth
		Daisy Hill Hospital	MUC	General Male Medical, Level 5	Minor		AWAREV		
		Craigavon Area Hospital	SEC	Trauma Ward	Minor		NREV	23/09/2014	Connie Connolly
		Daisy Hill Hospital	MUC	Emergency Department	Moderate		AWAREV		

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Personal Information redacted by the USI		Craigavon Area Hospital	MUC	1 South Medical	Insignificant	Personal Information redacted by the USI	FA	30/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	2 North Resp/Medical	Minor		FA	29/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	ED Majors	Moderate		FA	03/10/2014	Paul Smyth
		Craigavon Area Hospital	SEC	4 North	Moderate		INREV	23/09/2014	Connie Connolly
		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Minor		INREV		Mrs Patricia Kingsnorth
		Daisy Hill Hospital	FSS	General Male Medical, Level 5	Minor		FA	23/09/2014	Dorothy Morton
		Craigavon Area Hospital	MUC	2 North Resp/Medical	Minor		FA	29/09/2014	Sandra Burns
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		INREV		Mrs Patricia Kingsnorth

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Personal Information redacted by the USI		Craigavon Area Hospital	PHARM	Pharmacy Dispensary	Insignificant	Personal Information redacted by the USI	AWAREV		
		Craigavon Area Hospital	MUC	ED Clinical Decisions Unit	Major		FA	02/10/2014	Paul Smyth
		Craigavon Area Hospital	SEC	Trauma Ward	Major		INREV	23/09/2014	Connie Connolly
		Craigavon Area Hospital	MUC	Day Clinical Centre	Minor		AWAREV		
		Daisy Hill Hospital	MUC	ED Majors	Major		AWAREV		

ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	CCS	Day Procedure/Day Surgery Unit	Insignificant	Personal Information redacted by the USI	AWAREV		
		Craigavon Area Hospital	SEC	Orthopaedic Ward	Minor		FA	26/09/2014	Connie Connolly
		Craigavon Area Hospital	MUC	2 North Resp/Medical	Minor		FA	29/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	ED Clinical Decisions Unit	Moderate		FA	24/09/2014	Paul Smyth
		Craigavon Area Hospital	MUC	ED Clinical Decisions Unit	Moderate		FA	24/09/2014	Paul Smyth
		Craigavon Area Hospital	MUC	3 South	Minor		INREV		Hylda Patterson
		Daisy Hill Hospital	MUC	Stroke / Rehab	Minor		FA	03/10/2014	Anne Harris
		Craigavon Area Hospital	MUC	1 South Medical	Insignificant		INREV		Susan Mayne
		Craigavon Area Hospital	SEC	Car Park/Grounds	Minor		FA	26/09/2014	Connie Connolly
		Craigavon Area Hospital	FSS	Health Records	Minor		AWAREV		

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Personal Information redacted by the USI		Craigavon Area Hospital	FSS	ED Majors	Minor	Personal Information redacted by the USI	AWAREV		
		Craigavon Area Hospital	MUC	2 North Resp/Medical	Minor		A	25/09/2014	Sandra Burns
		Craigavon Area Hospital	MUC	Emergency Department	Minor		A	02/10/2014	Paul Smyth
		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Moderate		NREV	03/10/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	2 East Midwifery Led Unit	Minor		NREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	CCS	ICU (HDU)	Insignificant		A	26/09/2014	Brigeen Kelly
		Craigavon Area Hospital	IMWH	1 West Gynae	Minor		NREV		Mrs Patricia Kingsnorth
		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Minor		NREV	25/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	MAU	Insignificant		A	01/10/2014	Sandra Burns
		Daisy Hill Hospital	MUC	Female Medical, Level 5	Major		AWAREV		

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Personal Information redacted by the USI		Craigavon Area Hospital	FSS	ED Minors	Minor	Personal Information redacted by the USI	AWAREV		
		Daisy Hill Hospital	IMWH	Maternity Ward	Minor		INREV	26/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	1 West Gynae	Minor		INREV	26/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	ED Minors	Minor		FA	03/10/2014	Paul Smyth
		Daisy Hill Hospital	FSS	Entrance/Exit	Minor		FA	29/09/2014	Dorothy Morton
		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Minor		FA	26/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	2 Medical	Insignificant		AWAREV		

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Personal Information redacted by the USI		Armagh Community Hospital	CSCG	Opthamology Clinic	Insignificant	Personal Information redacted by the USI	AWAREV		
		Craigavon Area Hospital	MUC	Day Clinical Centre	Minor		AWAREV		
		South Tyrone Hospital	CCS	Day Procedure/Day Surgery Unit	Insignificant		INREV	25/09/2014	Marie Wilson
		Craigavon Area Hospital	CCS	ICU (HDU)	Insignificant		FA	26/09/2014	Brigeen Kelly
		Daisy Hill Hospital	SEC	Male Surgical/HDU	Moderate		INREV	26/09/2014	Connie Connolly
		Craigavon Area Hospital	MUC	Day Clinical Centre	Moderate		AWAREV		
		Craigavon Area Hospital	CCS	ICU (HDU)	Minor		INREV	26/09/2014	Brigeen Kelly
		Craigavon Area Hospital	MUC	MAU	Minor		FA	01/10/2014	Sandra Burns
		Craigavon Area Hospital	IMWH	2 West Maternity Post Natal	Minor		INREV	25/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Moderate		INREV		Mrs Patricia Kingsnorth

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Personal Information redacted by the USI		Daisy Hill Hospital	SEC	Male Surgical/HDU	Insignificant	Personal Information redacted by the USI	INREV	26/09/2014	Connie Connolly
		Daisy Hill Hospital	SEC	Male Surgical/HDU	Insignificant		INREV	26/09/2014	Connie Connolly
		Lurgan Hospital	FSS	Corridor/Stairs	Insignificant		FA	25/09/2014	Neil Casey
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		INREV	26/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	1 West Gynae	Minor		INREV		Mrs Patricia Kingsnorth
		Daisy Hill Hospital	MUC	Emergency Department	Moderate		INREV	03/10/2014	Paul Smyth
		Craigavon Area Hospital	SEC	4 NORTH STOMA CLINIC	Moderate		INREV	29/09/2014	Connie Connolly
		Craigavon Area Hospital	CCS	Theatre	Minor		INREV	26/09/2014	Brigeen Kelly

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Personal Information redacted by the USI		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Minor	Personal Information redacted by the USI	INREV	26/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	SEC	3 South	Moderate		INREV	29/09/2014	Connie Connolly
		Daisy Hill Hospital	MUC	ED Majors	Moderate		AWAREV		
		Craigavon Area Hospital	MUC	1 North Cardiology	Major		AWAREV		
		Craigavon Area Hospital	MUC	1 North Cardiology	Moderate		AWAREV		
		Craigavon Area Hospital	MUC	ED Clinical Decisions Unit	Minor		FA	02/10/2014	Paul Smyth
		Craigavon Area Hospital	CCS	Theatre	Minor		INREV		Pamela Mulholland
		South Tyrone Hospital	SEC	Theatre	Moderate		INREV		Sharon Glenny
		Craigavon Area Hospital	MUC	ED Majors	Moderate		FA	03/10/2014	Paul Smyth
		Daisy Hill Hospital	MUC	Stroke / Rehab	Moderate		AWAREV		

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Personal Information redacted by the USI		Craigavon Area Hospital	MUC	2 South Stroke	Minor	Personal Information redacted by the USI	FA	03/10/2014	Sandra Burns
		Craigavon Area Hospital	SEC	3 South	Minor		INREV	29/09/2014	Connie Connolly
		Craigavon Area Hospital	MUC	2 North Resp/Medical	Minor		FA	29/09/2014	Sandra Burns
		Daisy Hill Hospital	FSS	ED Majors	Moderate		AWAREV		
		Craigavon Area Hospital	FSS	ED Minors	Insignificant		AWAREV		
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		INREV	03/10/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Moderate		FA	01/10/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	IMWH	2 West Maternity Post Natal	Minor		INREV	29/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	SEC	Theatre	Moderate		INREV	29/09/2014	Connie Connolly
		Craigavon Area Hospital	SEC	Orthopaedic Ward	Minor		INREV	29/09/2014	Connie Connolly
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Major		INREV		Mrs Patricia Kingsnorth

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Personal Information redacted by the USI		Craigavon Area Hospital	MUC	ED Majors	Moderate	Personal Information redacted by the USI	NREV	03/10/2014	Paul Smyth
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Moderate		NREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	ED Clinical Decisions Unit	Minor		NREV	03/10/2014	Paul Smyth
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Moderate		NREV	29/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	ED Clinical Decisions Unit	Moderate		AWAREV		
		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Minor		NREV	03/10/2014	Mrs Patricia Kingsnorth
		Daisy Hill Hospital	MUC	X-ray Dept (Radiology)	Moderate		AWAREV		
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		NREV		Mrs Patricia Kingsnorth
		Daisy Hill Hospital	IMWH	Delivery Suite, DHH	Moderate		NREV		Mrs Patricia Kingsnorth
		Daisy Hill Hospital	MUC	ED Majors	Major		NREV	02/10/2014	Paul Smyth

ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	MUC	2 South Medical	Moderate	Personal Information redacted by the USI	AWAREV		
		Daisy Hill Hospital	FSS	CT Scanner	Minor		FA	29/09/2014	Dorothy Morton
		Daisy Hill Hospital	FSS	ED Majors	Minor		AWAREV		
		Craigavon Area Hospital	MUC	1 North Cardiology	Minor		AWAREV		
		Craigavon Area Hospital	FSS	Staff accommodation	Insignificant		AWAREV		
		Daisy Hill Hospital	FSS	ED Majors	Moderate		AWAREV		
		Craigavon Area Hospital	MUC	ED Majors	Minor		NREV	03/10/2014	Paul Smyth
		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Minor		NREV	02/10/2014	Mrs Patricia Kingsnorth
		South Tyrone Hospital	MUC	Car Park/Grounds	Minor		NREV	02/10/2014	Paul Smyth
		Craigavon Area Hospital	IMWH	2 East Midwifery Led Unit	Minor		NREV	30/09/2014	Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	2 North Haematology	Moderate		NREV	01/10/2014	Annette Burrows

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Personal Information redacted by the USI		Craigavon Area Hospital	IMWH	Delivery Suite, CAH	Major	Personal Information redacted by the USI	INREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	SEC	Trauma Ward	Minor		AWAREV		
		Craigavon Area Hospital	SEC	Trauma Ward	Minor		INREV		Rhonda Hunter
		Craigavon Area Hospital	MUC	ED Clinical Decisions Unit	Moderate		FA	03/10/2014	Paul Smyth
		Craigavon Area Hospital	MUC	Emergency Department	Minor		INREV	03/10/2014	Paul Smyth
		Daisy Hill Hospital	CCS	ED Resus	Major		AWAREV		
		Daisy Hill Hospital	MUC	General Male Medical, Level 5	Moderate		AWAREV		
		Daisy Hill Hospital	IMWH	Maternity Ward	Moderate		INREV		Mrs Patricia Kingsnorth
		Craigavon Area Hospital	MUC	1 North Cardiology	Minor		AWAREV		
		Daisy Hill Hospital	IMWH	Maternity Ward	Minor		INREV		Mrs Patricia Kingsnorth

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

ID	Incident date	Site	Division	Loc (Exact)	Severity	Description	Approval status	Date started (Investigation)	Handler
Personal Information redacted by the USI		Craigavon Area Hospital	MUC	2 North Resp/Medical	Minor	Personal Information redacted by the USI	A	30/09/2014	Sandra Burns
		Daisy Hill Hospital	MUC	Renal Unit	Minor		AWAREV		
		Craigavon Area Hospital	FSS	Laundry Room	Minor		A	03/10/2014	Anne Forbes

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

CCS incidents by Stage 1 January 2014 - 30 September 2014

CCS	Awaiting Review 18	Finally Approved 410	In Review 106	Rejected
2 East Midwifery Led Unit		1		
2 North Resp/Medical		1		
2 South Medical		3		
4 North	1			
Admissions/Assessment Unit		1		
Antenatal Clinic		1		
Audiology Clinic			1	
Bio-chemistry Lab	2	3		
Blood Transfusion Lab		3	1	
Breast Clinic	3		1	
Breast Screening Unit		1	3	
Cardiology Clinic	1			
CEAW		3		
Cellular Pathology Lab		2	1	
Corridor/Stairs			2	
CT Scanner		12	2	
Day Procedure/Day Surgery Unit	5	43	43	
Delivery Suite, CAH		2		
Delivery Suite, DHH		1		
ECT Suite			1	
ED Resus	1	2		
ED X-ray		9	2	
Emergency Department		4		
ENT Clinic		1		
Entrance/Exit	1	1		
Fracture Clinic		1		
General OutpatientsTreatment Room		1		
Haematology Clinic		3	2	
Haematology Lab		1		
Home of client			1	
ICU (HDU)		100	2	
Laboratory		3		
Lung Clinic, Mandeville Unit		1	2	
Male Surgical/HDU	1			
Microbiology Lab		1		
MRI Unit		5	4	
Oncology Clinic, Mandeville Unit	3	7	11	
Orthopaedic Ward		1		
Pain Management Clinic		1		
Public Toilets		1		
Reception/Waiting Area		1	1	
Recovery Unit		19	2	
Switchboard		1		
Theatre		126	13	
Trauma Ward		2		

Trauma/Orthopaedic Theatre	21	1
X-ray Dept (Radiology)	20	10

Total
534
1
1
3
1
1
1
1
5
4
4
4
1
3
3
2
14
91
2
1
1
3
11
4
1
2
1
1
5
1
1
102
3
3
1
1
9
21
1
1
1
2
21
1
139
2

22
30

FSS incidents by Stage 1 January 2014 - 30 September 2014

FSS	Awaiting Review 16	Finally Approved 394	In Review 10	Rejected 1
1 North Cardiology		3		
1 South Medical		18		
1 West Gynae		1		
2 East Midwifery Led Unit	1	2		
2 Medical		1		
2 North Haematology		1		
2 North Resp/Medical		7		
2 South Medical		1		
2 South Stroke		2		
2 West Maternity Post Natal		1		
3 South		6		
4 North	1	6		
4 NORTH STOMA CLINIC		1		
4 South		4		
Antenatal Clinic		1		
Basement		3		
Blood Transfusion Lab		5	1	
Boiler House		1		
Canteen/Dining Room		1		
Car Park/Grounds	2	17	1	
Carepoint		1		
CEAW		5		
Cloughmore Ward		1		
College of Nursing/ST Headquarters		1		
Coronary Care Ward, Level 5		7		
Coronation Building		1		
Corridor/Stairs		9		
CT Scanner		1		
Daisy Hill Resource Centre		1		
Day Clinical Centre		1		
Day Procedure/Day Surgery Unit		1		
Delivery Suite, DHH		1		
Dermatology Clinic		1		
Doctors Accommodation		4		
ED Clinical Decisions Unit		4		
ED Majors	6	27		
ED Minors	2	9		
ED Resus		5		
ED X-ray		1		
Emergency Department		17		
ENT Clinic		1		
Entrance/Exit		11		
Female Medical, Level 5		4		
Female Surgical/Gynae		2		
Finance Dept		1		

Firbank House		1		
Fracture Clinic	1	1		
General Male Medical, Level 5		11		
General Outpatients Reception/Waiting Area		1		
General OutpatientsTreatment Room		1		
Gynae Clinic		1		
Haematology Lab		2		
Health Records	1	2		
ICU (HDU)		1		
John Mitchel Place, HSSC		1		
Kitchen		11	1	
Laboratory		4		
Laundry Room		11		
Lift		4		
Male Surgical/HDU		7		
Maternity Ward		1		
MAU		27		
Minor Injuries Unit		1		
Mourne House		1		
Non Trust premises		1		
Opthamology Clinic		1		
Orthopaedic Ward		2	1	
Paediatric Ward		1	1	
Patient Flow Team		2		
Post Room			1	
Reception/Waiting Area	1	14		1
Recovery Unit		2		
Rehabilitation, Level 4		1		
Staff accommodation	1	6		
Sterile Services Dept		31		
Stroke / Rehab		8		
Switchboard		25		
The Rowans		1		
Theatre		2	2	
Trauma Ward		3		
Trauma/Orthopaedic Theatre		2	2	
Ulster Independant Clinic		2		
Waste Transfer Station		1		
Winter Pressures Ward(Ramone)		1		

Total
421
3
18
1
3
1
1
7
1
2
1
6
7
1
4
1
3
6
1
1
20
1
5
1
1
7
1
9
1
1
1
1
1
1
4
4
33
11
5
1
17
1
11
4
2
1

1
2
11
1
1
1
2
3
1
1
12
4
11
4
7
1
27
1
1
1
1
3
2
2
1
16
2
1
7
31
8
25
1
4
3
4
2
1
1

IMWH incidents by Stage 1 January 2014 - 30 September 2014

IMWH	Awaiting Review	Finally Approved	In Review	Rejected
		443	**264**	
1 East Maternity Antenatal			3	
1 West Gynae		40	26	
2 East Midwifery Led Unit		20	11	
2 West Maternity Post Natal		42	45	
Admissions/Assessment Unit		3	4	
Antenatal Clinic		13	27	
CEAW		1		
Colposcopy Clinic		4		
Corridor/Stairs		1		
Day Hospital			1	
Day Procedure/Day Surgery Unit		4	2	
Delivery Suite, CAH		138	67	
Delivery Suite, DHH		83	31	
Discharge Lounge		1		
Early Pregnancy Problem Clinic		3	2	
ED Clinical Decisions Unit		1		
Emergency Department			1	
Female Surgical/Gynae		11		
General Outpatients Reception/Waiting Area			1	
General OutpatientsTreatment Room		1		
Gynae Clinic		2	4	
Home of client		19	3	
John Mitchel Place, HSSC			1	
Kilkeel Health Centre		2		
Lift		1	1	
Maternity Ward		36	29	
Menopause Clinic		1		
Non Trust premises		1		
Portadown HSSC			1	
SAUCS (GPOOH) Armagh		1		
SAUCS (GPOOH) Craigavon		1		
Theatre		13	4	

Total
707
3
66
31
87
7
40
1
4
1
1
6
205
114
1
5
1
1
11
1
1
6
22
1
2
2
65
1
1
1
1
1
17

MUC incidents by Stage 1 January 2014 - 30 September 2014

MUC	Awaiting Review 168	Finally Approved 1410	In Review 153	Rejected 2
1 North Cardiology	5	66	24	
1 South Medical		140	2	
1 West Gynae	1		3	
2 Medical	2	29		
2 North Haematology		67	2	
2 North Resp/Medical		111	1	
2 South Medical	2	85	8	
2 South Stroke		54		
3 South			3	
4 North	2	1	1	
4 South			2	
Admissions/Assessment Unit	1	2	1	
Bronte Ward	1			
Car Park/Grounds	6	1	1	
Cardiac Catheterisation Lab		15	6	
Cardiology Clinic		1	1	
Cardiology Research		1		
CEAW	2			
Cellular Pathology Lab	1			
Chest Clinic	1			
Coronary Care Ward, Level 5	1	4	5	
CT Scanner			2	
Daisy Hill Resource Centre		1		
Day Clinical Centre	3	17	1	
Dermatology Clinic		41	9	
Dermatology Ward		4		
Diabetology Clinic	1			
ECG Clinic		1		
ED Clinical Decisions Unit	5	55	8	
ED Majors	2	165	15	
ED Minors	1	36	6	
ED Resus		25	9	
ED X-ray		1		
Emergency Department	4	71	11	1
Entrance/Exit	1	1		
Female Medical, Level 5	1	82	1	
Finance Department	1			
Fracture Clinic	1	1		
General Male Medical, Level 5	5	64	6	
General Medicine Clinic	3	1		
General Outpatients Reception/Waiting Area	1			
Male Surgical/HDU	2	1	1	
Maternity Ward	1			
MAU	98	135	14	1
Minor Injuries Unit			4	

MRI Unit		1	
Neurology Clinic		3	
Patient Flow Team			2
Pharmacy Dispensary		1	
Physiotherapy Outpatients Department	1		
Ramone Building	1		
Ramone Ward		5	
Reception/Waiting Area		4	
Rehabilitation, Level 4	1	6	
Renal Unit	2	2	
St Macartans Private Nursing Home Clogher	1		
Stroke / Rehab	3	84	2
Trauma Ward			1
Trauma/Orthopaedic Theatre		1	
Trust transport	1		
Ward 1, Stroke	1		
Ward 2, Assessment and Rehabilitation	1		
Winter Pressures Ward(Ramone)		23	
X-ray Dept (Radiology)	1	1	1

Total
1733
95
142
4
31
69
112
95
54
3
4
2
4
1
8
21
2
1
2
1
1
10
2
1
21
50
4
1
1
68
182
43
34
1
87
2
84
1
2
75
4
1
4
1
248
4

1
3
2
1
1
1
5
4
7
4
1
89
1
1
1
1
1
23
3

SEC incidents by Stage 1 January 2014 - 30 September 2014

SEC	Awaiting Review 9	Finally Approved 501	In Review 104	Rejected 1
		1		
1 West Gynae			1	
3 South		74	5	
4 North		48	25	1
4 NORTH STOMA CLINIC		1	1	
4 South		67	12	
Car Park/Grounds		3		
CEAW		60	1	
Day Procedure/Day Surgery Unit	7	6	7	
ED Clinical Decisions Unit		1		
Emergency Department			1	
ENT Clinic		3		
Entrance/Exit		2		
Female Surgical/Gynae		34	2	
Firbank House		1		
Fracture Clinic		5	1	
Gastroenterology Clinic		1		
General Outpatients Reception/Waiting Area		1		
General OutpatientsTreatment Room		5	1	
General Surgery Clinic		2		
Home of client		2		
Male Surgical/HDU		45	13	
Opthamology Clinic		1		
Orthopaedic Ward		22	7	
Paediatric Ward		5	5	
Pre-operative Assessment Clinic		3	3	
Public Toilets		1		
Recovery Unit		2		
Theatre		19	8	
Thorndale Unit		2		
Trauma Ward	2	69	8	
Trauma/Orthopaedic Theatre		4	2	
Ulster Independant Clinic			1	
Urology Clinic		10		
X-ray Dept (Radiology)		1		

Total
615
1
1
79
74
2
79
3
61
20
1
1
3
2
36
1
6
1
1
6
2
2
58
1
29
10
6
1
2
27
2
79
6
1
10
1

SAI Investigation Reports submitted awaiting closure by HSCB 01 April 2007 (historic) – 6 October 2014

SAI ID	Incident ID	Date report due	Incident description	Extension	Date Submitted	Comments
Personal Information redacted by the USI					07/01/2011	Submitted awaiting closure
				30/08/13	22/10/2013	Submitted awaiting closure
				16/09/13	02/10/2013	Submitted awaiting closure
				31/03/14	27/05/2014	Submitted awaiting closure
				14/02/14	18/02/2014	Submitted awaiting closure

SAI Investigation Reports not yet submitted 11 August 2014

SAI ID	Incident ID	Date report due	Incident description	Extension	Date Submitted	Comments
Personal Information redacted by the USI				Requested		Presentation at Acute Clinical Governance, 10 Oct 2014, by AMD
				Requested		With Independents & Chair
				Requested		Presentation at Acute Clinical Governance, 10 Oct 2014, by AMD
				Requested		Anne McVey to update on progress
				Requested		Presentation at Acute Clinical Governance, 10 Oct 2014, by AMD
				Requested		TOR forwarded to HSCB Meeting 3rd September; HSCB informed. ****Coroner URGENTLY awaiting report re making a decision regarding inquest****
				Requested		Report remains outstanding

Personal Information redacted by the USI	Requested		Further delay as planned meeting was cancelled. Extension to be requested.
	Requested		Report being drafted and final meeting to be arranged. Extension to 1 Nov 2014 to be requested
	Requested		To be updated at 2pm meeting
	Requested		Presentation at Acute Clinical Governance, 10 Oct 2014, by AMD
	Requested		Final meeting to be arranged to suit Dr C availability. Extension to be requested.
	Requested		To be updated at 2pm meeting
			Investigation yet to be commenced
	Requested		To be updated at 2pm meeting
			Draft report with Chair, then circulation to SAI Review group
			ED section complete. Report to be progressed within CYP.
			To be updated at 2pm meeting. ?Report completed

SAI Summary 6 October 2014

Submitted awaiting Closure	
Not yet submitted	5
Divisional Breakdown of Investigation Ongoing	
MUSC	10
SEC	3
CCS	1
IMWH	1
Cross Divisional Investigations Ongoing	
MUSC/SEC	1
Cross Directorate Investigations Ongoing	
Acute / CYP	1
Acute / OPPC	1

Southern Health and Social Care Trust

Quality Care - for you, with you

DIRECTORATE OF ACUTE SERVICES

Interim Director: Mrs Deborah Burns

Tel: Personal Information redacted by the USI

ACUTE DIRECTORATE GOVERNANCE MEETING

Date: Tuesday 7th October 2014

Apologies – Margaret Marshall, Anne McVey (Pat McVey attending), Heather Trouton (Martina Corrigan attending), Barry Conway.

1.0	**Chair's Business** • n/a	**Action**
2.0	**Patient Safety Programme Report** Colum presented his report. Sepsis audit – outperforming the College of Emergency Physicians audit benchmark which is excellent. Falls now spread to second phase – so every ward will be on-board by December. 1 South has shown a 37% decrease in the incidence of falls. Colum to get Debbie some bench marking data. Ronan to follow up on query re the CT question under stroke. Travel to patient safety collaborative is not possible under the current financial restrictions so they should be tele or video conference.	**Colum** **Ronan**
3.0	**Effectiveness & Evaluation** • Hyponatraemia Audit – the reports were discussed. There has been a great improvement in compliance. • VTE Weekly Audit – the report was discussed. In IWMH the issue with risk assessments is still being progressed. The responsibility for completion of the audit still lies with the medical staff. The next audit level is checking whether the prophylaxis has been prescribed. Anne and Raymond to discuss further.	**Raymond Haffey** **Anne Q, Colum, Margaret & Raymond**
4.0	**Complaints Report –** the report was discussed. There has been excellent progress on the complaints work. The Acute Governance team's involvement in the complaints work was discussed and it was decided that the governance team's role would be to consider the implementation of any learning resulting from the complaints. Current management process would remain the same.	**Tracey**
5.0	**Equipment Management & Medical Device** • Internal Audit Schedules and Performance Reports – Anne discussed an alternative approach. One video conference now with the internal auditors to go ahead – to get the audits back on schedule.	**Anne Q**

6.0	**SAIs:** SAI Investigation Reports as at 6 October 2014 – 5 submitted to HSCB and closed. Four to be circulated for the Friday Clinical Governance meeting, with the AMD to present their SAI. Anne and Debbie to meet to discuss this report further with a view to addressing any backlog. Patient Safety Quality Team Process for SAIs – Anne presented the draft SAI process map circulated. Debbie would like the screening forms regardless of whether the incident turns out to be an SAI or not.	**Anne & Debbie** **Anne Q**
7.0	**Directorate Risk Register –** B/F to next meeting	
8.0	**Standards & Guidelines:** NICE 73 – interim position as at mid November 2014 - Anne Q gave an update and suggested that she would go to AMDs and agree one primary change lead for each item – agreed.	**Anne Q**
9.0	**Incidents** The new draft report on incident management produced by David and Vivienne was considered. The report was very helpful and it was decided that this should go to ADs on a weekly basis, as well as the Acute Governance Team. Tracey to arrange. The large number of 'un-reviewed' and 'under review' incidents were discussed. it was agreed that Connie and Paul would concentrate on the un-reviewed MUSC incidents this week, looking for any of concern and then arrange to meet with Simon and Anne McV on Monday to discuss and plan action. Next week the focus would move to the 'under-review' category.	**Tracey** **Simon and Anne**
10.0	**Any Other Business** • Reports for monthly Governance meetings – agreed it would be SAI report, incident report, complaints report, Major and above incidents report, patient safety, report, summary Patient Support report and Audit Summary report. • Signing off IR1s under new arrangements	
11.0	**Date of next meeting** The next Governance meeting will be held on Tuesday 4th November 2014 at 2.45 pm in the Meeting Room, Admin Floor, CAH	

Stinson, Emma M

From:	Stinson, Emma M [redacted]
Sent:	03 December 2013 11:32
To:	Boyce, Tracey; Donaghy, Gary; Cassells, Carol; Dougan, David; Carroll, Anita; Carroll, Ronan; Conway, Barry; Gibson, Simon; McVey, Anne; Trouton, Heather
Cc:	Burns, Deborah; Conlon, Noeleen; Graham, Michelle; Lappin, Aideen; Murphy, Jane S
Subject:	*Revised Dates for the Diary* Acute Directorate Finance Meetings 2014
Attachments:	Acute Directorate Finance Meetings 2014.docx; image003.png; image004.jpg; image005.png; image006.png

Dear all

To facilitate attendance from Finance at the Divisional meetings I have amended some dates/times on the attached schedule and would be grateful if you would update your diaries.

I apologise for any inconvenience caused.

Many thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Direct Line: [redacted] Direct Fax: [redacted]
[redacted]
P Please consider the environment before printing this email

Click on the link below to access the Acute Services - Home Page

From: Stinson, Emma M
Sent: 19 November 2013 13:03
To: Boyce, Tracey; Donaghy, Gary; Cassells, Carol; Dougan, David; Carroll, Anita; Carroll, Ronan; Conway, Barry; Gibson, Simon; McVey, Anne; Trouton, Heather
Cc: Burns, Deborah; Conlon, Noeleen; Graham, Michelle; Lappin, Aideen; Murphy, Jane S
Subject: *Dates for the Diary* Acute Directorate Finance Meetings 2014

Dear all

Please find attached the schedule of Finance meetings for 2014 for your diary. I would be grateful if you would forward to your Heads of Service for their attendance as necessary.

Many thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Direct Line: Personal Information redacted by the USI Direct Fax: Personal Information redacted by the USI
Personal Information redacted by the USI

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Acute Directorate Finance Meetings 2014

All meetings are in the Meeting Room, Admin Floor unless otherwise advised

8th January 2014 **AMENDED**

Division	Time	Venue
MUSC	9.30 am	Debbie's office
SEC	10.00 am	Debbie's office
CCS	10.30 am	Debbie's office
IMWH	11.00 am	Debbie's office
Pharmacy	11.30 am	Debbie's office
FSS	12 noon	Debbie's office

7th February 2014

Division	Time
MUSC	9.00 am
SEC	9.45 am
CCS	10.30 am
IMWH	11.15 am
Pharmacy	12 noon
FSS	12.30 pm

7th March 2014

Division	Time
MUSC	9.00 am
SEC	9.45 am
CCS	10.30 am
IMWH	11.15 am
Pharmacy	12 noon
FSS	2.00 pm

7th April 2014

Division	Time
MUSC	9.00 am
SEC	9.45 am
CCS	10.30 am
IMWH	11.15 am
Pharmacy	12 noon
FSS	12.30 pm

8th May 2014

Division	Time	Venue
MUSC	9.00 am	Seminar Room 1, MEC
SEC	9.45 am	Seminar Room 1, MEC
CCS	10.30 am	Seminar Room 1, MEC
IMWH	11.15 am	Seminar Room 1, MEC
Pharmacy	12 noon	Seminar Room 1, MEC
FSS	12.30 pm	Seminar Room 1, MEC

9th June 2014

Division	Time
MUSC	9.00 am
SEC	9.45 am
CCS	10.30 am
IMWH	11.15 am
Pharmacy	12 noon
FSS	12.30 pm

7th July 2014

Division	Time
MUSC	9.00 am
SEC	9.45 am
CCS	10.30 am
IMWH	11.15 am
Pharmacy	12 noon
FSS	12.30 pm

7th August 2014

Division	Time	Venue
MUSC	9.00 am	Seminar Room 1, MEC
SEC	9.45 am	Seminar Room 1, MEC
CCS	10.30 am	Seminar Room 1, MEC
IMWH	11.15 am	Seminar Room 1, MEC
Pharmacy	12 noon	Seminar Room 1, MEC
FSS	12.30 pm	Seminar Room 1, MEC

5th September 2014 AMENDED

Division	Time
MUSC	9.00 am
SEC	9.45 am
CCS	10.30 am
IMWH	11.15 am
Pharmacy	12 noon
FSS	1.30 pm

7th October 2014 AMENDED

Division	Time	Venue
MUSC	9.00 am	Board Room, Main Hospital, CAH
SEC	9.45 am	Board Room, Main Hospital, CAH
CCS	10.30 am	Meeting Room, Admin Floor
IMWH	11.15 am	Meeting Room, Admin Floor
Pharmacy	12 noon	Meeting Room, Admin Floor
FSS	12.30 pm	Meeting Room, Admin Floor

7th November 2014 AMENDED

Division	Time
MUSC	9.00 am
SEC	9.45 am
CCS	10.30 am
IMWH	11.15 am
Pharmacy	12 noon
FSS	12.30 pm

5th December 2014 AMENDED

Division	Time
MUSC	9.00 am
SEC	9.45 am
CCS	10.30 am
IMWH	11.15 am
Pharmacy	12 noon
FSS	12.30 pm

Stinson, Emma M

From:	Lappin, Aideen <[redacted]>
Sent:	22 October 2013 11:43
To:	Clayton, Wendy; Glenny, Sharon; McAreavey, Lisa; Richardson, Phyllis; Lappin, Lynn; Conway, Barry; Carroll, Ronan; Trouton, Heather
Cc:	Stinson, Emma M; Graham, Michelle; Conlon, Noeleen; Murphy, Jane S; Livingston, Laura
Subject:	Performance team meetings with Lynn Lappin
Attachments:	Performance meetings 2013.docx

Dear all

Please see attached for details of the Performance meetings with Lynn Lappin and Debbie Burns – please amend your diaries accordingly.

Many thanks
Aideen

Aideen Lappin
Secretary for Anita Carroll
Assistant Director of Acute Services -
Functional Support Services
5 Hospital Road
Newry
Co. Down
BT35 8DR

Tel: [redacted]
Fax: [redacted]

From: Carroll, Anita
Sent: 03 October 2013 11:27
To: Carroll, Ronan; Trouton, Heather; Conway, Barry; McVey, Anne
Cc: Lappin, Lynn; Graham, Michelle; Murphy, Jane S; Leeman, Lesley; Stinson, Emma M; McAreavey, Lisa; Clayton, Wendy; Richardson, Phyllis; Glenny, Sharon
Subject: RE: perf team meetings with lynn

Hi all speaking to lesley and for eg on w/c 7th 3 meetings are on wed

9.00 ccs
11.30 sec
1.00 musc
Anne your meeting is thurs at 12.00 so could we bring this say to 9.45 and finish at 10.30on the wed

And then if there's any scope to start heathers or Barry earlier But thereafter try to keep to half a day

The next week w/c 14th they are on thurs 17th

12.00 musc
1.00 ccs
2.00 imwh
3.00 sec

So this could be go ahead ideally it would be best if they rang
1 all on one day and restrict to morning or afternoon session

Anita

From: Carroll, Ronan
Sent: 03 October 2013 10:31
To: Carroll, Anita; Trouton, Heather; Conway, Barry; McVey, Anne
Cc: Lappin, Lynn; Graham, Michelle; Murphy, Jane S; Leeman, Lesley
Subject: RE: perf team meetings with lynn

Anita
For us we discuss performance every Tuesday at 9am – happy that we use this time for us Ronan

Ronan Carroll
Assistant Director Acute Services
Cancer & Clinical Services/ATICs
Personal Information redacted by the USI

From: Carroll, Anita
Sent: 03 October 2013 10:29
To: Carroll, Ronan; Trouton, Heather; Conway, Barry; McVey, Anne
Cc: Lappin, Lynn; Graham, Michelle; Murphy, Jane S; Leeman, Lesley
Subject: perf team meetings with lynn

Dear all

As Debbie suggested can these all be sequenced to minimise lynns time and logistics of different days Can we confirm from next week these will all be on ? tues and do you each want to select a time If you are happy could we get one of the girls say Jane or Michelle to set up and confirm the detail Thanks Anita

---

Mrs Anita Carroll
Assistant Director of Acute Services
Functional Support Services
Daisy Hill Hospital
5 Hospital Road
Newry
Co. Down
BT35 8DR

Tel: Personal Information redacted by the USI
Fax: Personal Information redacted by the USI

Cancer and Clinical Services **meetings with Lynn Lappin**	**Time**	**Venue**
26th November	9am	Meeting Room, Admin Floor, CAH
4th December *Debbie attending*	12.30pm	Meeting Room, Admin Floor, CAH
10th December	9am	Meeting Room, Admin Floor, CAH
18th December *Debbie attending*	12noon	Debbie's office

Medicine & Unscheduled Care **meetings with Lynn Lappin**	**Time**	**Venue**
26th November	9.40am	Meeting Room, Admin Floor, CAH
4th December *Debbie attending*	9.15am	Barry's office
10th December	9.40am	Meeting Room, Admin Floor, CAH
18th December *Debbie attending*	9.15am	Barry's office

Integrated Maternity, Women's Health & Neonatology **meetings with Lynn Lappin**	**Time**	**Venue**
26th November	10.30am	Meeting Room, Admin Floor, CAH
4th December *Debbie attending*	12 noon	Debbie's office
10th December	10.30am	Meeting Room, Admin Floor, CAH
18th December *Debbie attending*	11am	Debbie's office

Surgery & Elective Care **meetings with Lynn Lappin**	**Time**	**Venue**
26th November	11.30am	Meeting Room, Admin Floor
4th December *Debbie attending*	11.30am	Meeting Room, Admin Floor
10th December	11.30am	Meeting Room, Admin Floor
18th December *Debbie attending*	11.30am	Meeting Room, Admin Floor

Performance **meetings with Lynn Lappin - 2014**	**Division / Time**	**Venue**
15th January 2014 *Debbie attending*	C&CS - 9am	Debbie's office, Admin Floor, CAH
28th January 2014		
12th February 2014 *Debbie attending*		
25th February 2014	MUSC - 9.40am	
12th March 2014 *Debbie attending*		
25th March 2014		
9th April 2014 *Debbie attending*	IMWH - 10.30am	
23rd April 2014		
7th May 2014 *Debbie attending*		
20th May 2014	SEC - 11.30am	
4th June 2014 *Debbie attending*		
17th June 2014		
2nd July 2014 *Debbie attending*		
29th July 2014		
13th August 2014 *Debbie attending*		
26th August 2014		
10th September 2014 *Debbie attending*		
23rd September 2014		

8th October 2014 *Debbie attending* 21st October 2014 5th November 2014 *Debbie attending* 18th November 2014 2nd December 2014 *Debbie attending* 16th December 2014		

Attendees Anita Carroll, Wendy Clayton, Sharon Glenny, Lisa McAreavey, Phyllis Richardson, Lynn Lappin, Debbie Burns, Barry Conway, Ronan Carroll, Heather Trouton

Stinson, Emma M

From: Glenny, Sharon [redacted]
Sent: 28 November 2013 15:54
To: Stinson, Emma M; Clayton, Wendy; McAreavey, Lisa; Richardson, Phyllis
Cc: Trouton, Heather; Corrigan, Martina; Reid, Trudy; Nelson, Amie
Subject: RE: VERY URGENT+++ FOR TODAY++++
Attachments: SEC Performance Update for Mon 25.11.13.xlsx; PERFORMANCE NOTES 29.11.13.docx; image001.png; image002.png; image003.jpg

Hi Emma

As requested – please see attached from SEC.

Sharon

From: Stinson, Emma M
Sent: 28 November 2013 13:21
To: Clayton, Wendy; Glenny, Sharon; McAreavey, Lisa; Richardson, Phyllis
Subject: VERY URGENT+++ FOR TODAY++++

Dear all

Please see below – could you provide me with this report by return and highlight areas of concerns so I can pull to relevant departments together for this afternoon?

Many thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Direct Line: [redacted] Direct Fax: [redacted]
[redacted]

P Please consider the environment before printing this email

Click on the link below to access the Acute Services - Home Page

From: Lappin, Lynn
Sent: 28 November 2013 12:42
To: Stinson, Emma M
Subject: RE: VERY URGENT+++ FOR TODAY++++

Emma

The OSLs should have a composite report for this week's performance and SBA positions. I was not available to meet with the Divisions this week but they should have all met yesterday.

I am up with Debbie at 3pm re: IMWH. Might be useful to get the composite report of the OSLs and ask them which areas are a risk and then have a discussion with the relevant areas at 4pm?

Regards.

Lynn

Lynn Lappin
Head of Performance

Directorate of Performance & Reform
Southern Health & Social Care Trust
The Rowans
Craigavon Area Hospital
68 Lurgan Road
PORTADOWN
BT63 5QQ

Direct Dial: Personal Information redacted by the USI
Blackberry: Personal Information redacted by the USI
E-mail: Personal Information redacted by the USI

From: Stinson, Emma M
Sent: 28 November 2013 11:27
To: Lappin, Lynn
Subject: FW: VERY URGENT+++ FOR TODAY++++

Hi Lynn

I know we had these meetings last week in preparation for the Elective Care Monitoring meeting last Friday – Is there a report that could be shared with Debbie or would you be available this afternoon and I will try and pull the divisions together? (I know we already have a slot for IMWH this pm).

Many thanks
Emma

Emma Stinson
PA to Mrs Deborah Burns
Interim Director of Acute Services
Southern Health and Social Care Trust
Admin Floor
Craigavon Area Hospital

Direct Line: Personal Information redacted by the USI Direct Fax: Personal Information redacted by the USI
Personal Information redacted by the USI

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From: Burns, Deborah
Sent: 28 November 2013 06:08
To: Stinson, Emma M
Subject: VERY URGENT+++ FOR TODAY++++

Emma I am at director meeting Belfast this Friday – we haven't had a perf meeting this week?? Have these got out of sink?? Need everyone to give an update this pm somewhere in diary – 2.30 to 4 probably - need everyone to come in and give an update D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

PERFORMANCE UPDATE WEEK BEGINNING 25.11.13 - ACCESS POSITION

			2012/2013 Baseline	2013/2014	November 2013								December 2013 - Excludes November 2013								IHA/IS Monitoring							1/4/13 - 21/11/13		
Division	Specialty	Activity Type	End March Access Position	HSCB Access Standard / Backstop	Total on PTL	Booked in-month	Not booked - in PB cycle for in-month	Not booked - not in PB cycle	Booked Beyond Breach	Current Month-End Projected Access Position (Longest waiter)	Projected Volumes in Excess of HSCB Access Standard / Backstop	Comments / Risks / Actions	Total on PTL	Booked in-month	Not booked - in PB cycle for in-month	Not booked - not in PB cycle	Booked Beyond Breach	Current Month End Longest Waiter if no plan found (without a date, not in PB cycle, BBB, WLS)	Projected month end Access Position (Longest Waiter)	Projected Volumes in Excess of Access Standard / Backstop	Comments / Risks / Actions	Q1&2 Allocation	Q1&2 Actual Activity	Variance on Q1&2	Modified Q3 Allocation	Q 3 Cumulative Actual IS Activity	Q3 Cumulative Actual IHA Activity	TOTAL cumulative IHA/IS Activity	IHA/IS Variance	IHA/IS Variance %	Comment
SEC	Breast Surgery	IP	30-weeks	30-weeks	0	0	-	0	0	-	-	All patients to meet 26 weeks have been treated.	1	0	-	0	0	30-weeks	30-weeks	1	Capacity problems for December due to red flag/cancer cases and possibility that there may be no PTL patients scheduled into December escalated to HOS on 21.11.13 - advice awaited										
SEC		DC	30-weeks	30-weeks	0	0	-	0	0		-		2	0	-	0	0	28-weeks	28-weeks	2											
SEC		IP/DC	30-weeks	30-weeks	0	0	-	0	0	25-weeks	-		3	0	-	0	0	28-weeks	28-weeks	3											
SEC	Endoscopy	IP	17-weeks	9-weeks	1	0	-	1	0	11-weeks	0	4 patients not booked are with ISP - escalated to IS Team. 1 patient [redacted] is IH - this is for a named cons only who has no remaining capacity in November - options re another cons treating or treated on IP list being explored. 70 Patients will be in excess of the 9 week target by end November.	3	2	-	1	0	12-weeks	11-weeks	0	**These figures are to hold 11 weeks in December as approval for additional IHA in December is still awaited. There are 30 patients with ISP for December to hold 11 weeks - 20 have dates, 10 no dates - all have been escalated to IS team. There is adequate core capacity to hold 11 week target in December - the remaining 32 IH patients have been forwarded to the schedulers for urgent attention. There are an additional 98 patients requiring dates IH for 10 week PTL - schedulers aware and are working through the list.	768	692, now revised to 840 per JA 19.11.13	-72	312	148	93	241	71	77%	Activity for Q3 has been calculated on specialty coding rather than clinical coding, given the delays with IS clinical coding. There are a further 60 patients to be treated in ISP to meet 10 weeks in December, leaving a volume of 11 for IHA (this is based on over-activity being in Q1/2 being taken from Q3 allocation) - 19 IHA remain to be treated before end November. Lynn has sought further additional funding allocation for the IHA put in place in December, however, this was based on original activity of 692 for Q1/2 and not the new revised activity of 840.
SEC		DC			94	90	-	3	1				302	260	-	42	0	15-weeks	11-weeks	0											
SEC		IP/DC			95	90	-	4	1				305	262	-	43	0	15-weeks	11-weeks	0											
SEC	ENT	NOP	9-weeks	9-weeks	508	136		90	282	12 Weeks	372	12 week PTL - 45 patients with dates in November; 2 patients not booked (2 x U18 - escalated to RBC). 9 week PTL - 508 patients; 90 patients not booked. (Longest waiters = U18 x 2 escalated (16 weeks & 15 weeks). Longest waiters booked = 12 weeks x 5 (all with December dates)	1089	390	99	587	1	16 weeks	12 Weeks		Current LW 1 x 16 weeks U18 discharge Next LW not booked = 1 x 11 weeks 1 Booked January x 6 weeks Not Booked includes 10 IS patients wating between 4- 8 weeks **15 Not Booked to Maintain 12 Week WT at end of December -**	875	1054	179	258	127	130	257	-1	0%	If Advise IS to work to 17 weeks will reduced IS spend by 4 patients - therefore potentiall over by 3 patients
SEC		IP	26-weeks	13-weeks	60	15		5	40	19 Weeks	45	5patients with STF - no dates yet (all 15 weeks). 9 patients with no dates (LW 16 wks x 1, 15 wks x 5, 14 wks x 3). [redacted] - Jan 2014 20 week waiter on PTL should have been WLS (work commitments - refused Dec dates).	93	57	0	69	1	21 weeks	17 weeks		**17 Weeks end of December -** 10 IP Not Booked LW 16 weeks (includes 4 IS Patients) 7 DC Not Booked LW 15 weeks (includes 2 IS Patients)	170	99	-71	85	40	56	96	11	13%	
SEC		DC			40	15		9	16	19 Weeks	25		157	63	0	92	2	22 Weeks	17 weeks												
SEC		IP/DC			100	30		14	56	19-weeks	70		250	120	0	161	3	22 Weeks	17 weeks												
SEC	General Surgery	NOP	9-weeks	9-weeks	97	96	0	1	0	9-weeks	0	Last remaining patient with STF - no date as yet - escalated to IS Team. All patients with a date in November are IH - no ISP with dates remaining.	741	493	175	73	0	13 weeks (not triaged)	9 weeks	0	81 of the patients booked have dates in November. 4 patients only with ISP for December - resets as no direct transfers. A total capacity of 545 core (based on CBK 19.11.13) and 165 IHA NOP slots are available in December, ie a total of 710 NOP slots. There are 412 patients booked and 175 in PB cycle, ie a total of 587 offers out. Effectively there is a difference of 123 NOP offers vs available slots and 78 patients not in PB cycle - RBC has been asked for update regarding same.	1630	1447	183	565	120	198	318	-247	-44%	A volume of 250 was returned to HSCB. A request for return of 90 has been made following specialism modelling. Projected end December = 124 IS and 530 IHA - a total of 654.
SEC		IP	47-weeks	30-weeks	6	6	0	0	0	26-weeks	1	One patient back onto waiting list - cancelled by hospital on Friday - escalated to HOS 23.11.13. Options will be explored for in-month solution. Last week's vascular patients which were cancelled for an urgent case have all now been offered alternative November dates for surgery.	18	14	0	4	0	38 weeks (WLS)	26 weeks		Virtual scheduling for December has demonstrated that with some movement of patients between consultants, there is no apparent capacity gap at present, although there are still 20 patients yet to be scheduled. I have requested a focus on scheduling these patients this week.	472	215	257	236	74	41	115	-121	-51%	IHA lower than expected - need to check what has been recorded to ensure all under WLIO codes. Surge of IS washthrough in Q4 expected - Lynn making case for under-utilisation in Q1&2 and potentially this quarter to be used to offset Q4 bulge.
SEC		DC			6	5	0	1	0				74	58	0	16	0	36 weeks (WLS)	26 weeks	0											
SEC		IP/DC			12	11	0	1	0				92	72	0	20	0	38 weeks (WLS)	26 weeks												
SEC	Opthalmology	NOP	18-weeks	18-weeks	27	26	0	1	0	25-weeks	326 in excess of 15 week backstop	1 x U18 discharge - escalated to Katherine	108	71	15	22	0	26 weeks (cataract)	24 weeks	0	Patients not in PB - 18 are with ISP, 2 are U18 discharge, 2 are cataracts not selected as yet for December	800	767	-33	400	197	0	197	-203	-51%	All ISP transfers - batch 1 - 200 sent on 02.10.13 and 158 accepted, batch 2 - sent 128 on 04.11.13 and 83 accepted, batch 3 - sent 157 on 20.11.13 and assuming pick of 126. Therefore sending a batch of 20 in next few days as top-up. Will revisit at end of first week in December
SEC		DC	13-weeks	13-weeks	2	2	-	0	0	13-weeks	0	No risk	13	8	-	5	0	17 weeks (ISP)	13 weeks	0	5 patients with ISP - 2 booked, 3 not booked. Remaining 2 IH patients passed to scheduling team for action.	491	644	153	22	67	0	67	45	205%	All washthrough activity with ISP. Allocation for Q3 was 175.
SEC	Orthopaedics	NOP	13-weeks	13-weeks	24	23	1	0	0	13-weeks	0	The patient in PB cycle is with ISP, 2 others to be treated by end of November with ISP to meet target - late transfers, but accepted ISP.	141	87	16	38	0	15-weeks (ISP)	13-weeks	0	21 patients with ISP for December PTL. 17 patients not in PB cycle still remain thereafter split as follows: 2 x JMcC, 5 x LW, 3 x RMcK, 1 x SP U18 discharge, 6 x GORTH-2LL&4UL. A plan for appointnents has been sent to Katherine/RBC for action	342	298	44	171	10	114	124	-47	-27%	6 x JMcC clinics and 1x LW clinic in December - a total of 70 NOPs - this will be above the allocation. A extra volume of 18 IHA and 30 IS has been requested by Lynn to cover projected shortfall
SEC		IP	48-weeks	30-weeks	3	2	-	1	0	26-weeks	0	The one patient without a date should be WLS - request to Sarah to update.	31	17	-	14	0	32-weeks (WLS)	still hopeful for 26 weeks	3 patients remaining to meet target	21 patients with ISP - 10 with dates, 11 without dates. 15 patients for IH dates, 6 of which are currently WLS.	596	322	274	115	73	31	104	-11	-10%	December JMcC sessions - 18 patients scheduled. Also 25 patients with ISP. Discussed with Lynn 28.11.13 re Q3 figure which was used.
SEC		DC			1	1	-	0	0				20	8	-	12	0	37-weeks (WLS)												
SEC		IP/DC			4	3	-	1	0				51	25	0	26	0	37-weeks (WLS)												
SEC	Urology	NOP (includes ICATS)]	17-weeks (ICATS)	9-weeks	130	25		95	10	19-weeks	105	ICATS 27 week PTL - cleared. ICATS 15 weeks - projected longest waiter at month end is 26 weeks LUTS [redacted] to Dec) and 19 weeks Andrology (not in PBC). Cons-Led 15 weeks = LW at month end is 16 weeks (originally ICATS pt)	136	47	4	89	0	26-weeks (LUTS)	22-weeks (LUTS)	65 patients in excess of 15 weeks (LUTS)	PB letters delayed in going out due to the volume of untriaged referrals. LUTS patients will remain a problem in December due to the support required for this particular cohort of patients. Discussion at urology departmental meeting 28.11.13 - LUTS to meet 22 weeks being scheduled to Mr Suresh with support from Jenny.										
SEC		IP	30-weeks	30-weeks	127	7		109	11	90-weeks	120		155	19	-	136	0			4 patients for 58 weeks still with no date - has been escalated to consultants each week and HOS											
		DC	30-weeks	30-weeks	90	23		67	7	61-weeks	74	Longest waiters not booked by month end is 62 weeks x 1, 61 weeks x 1, 57 weeks x 2, 56 weeks x 2	135	36	-	99	0	58-weeks	58-weeks											
SEC		IP/DC	30-weeks	30-weeks	217	18	-	181	18	61-weeks	199		290	55	-	235	0													
SEC	Urodynamics (Urology)	Diag	44-weeks	9 - weeks	71	5	0	62	4	59 weeks	66 in excess of 9 weeks		93	16	0	77	0	56-weeks	56-weeks	77 patients in excess of 9 week target											

PERFORMANCE UPDATE WEEK BEGINNING 25.11.13 - SBA POSITION

			2013/2014 Baseline		NOVEMBER - CUMULATIVE FROM 1/4/13 - 21/11/13					DECEMBER PROJECTIONS				
Division	Specialty	Activity Type	2013/14 SBA (ANNUM)	MONTHLY EXPECTED SBA	CUMULATIVE EXPECTED SBA	CUMULATIVE ACTUAL	Current SBA Variance	Current SBA Variance %	END NOV SBA PROJECTION	CUMULATIVE EXPECTED SBA	CUMULATIVE PROJECTED SBA	PROJECTED SBA Variance	PROJECTED SBA VARIANCE %	SBA Comments / Actions / Risks
SEC	Breast Surgery	IP	299	25	196	161	-35	-17.86%						Please refer to Breast modelling paper. 5 x lost sessions in December - 2 x SOW, 2 x Bank Holidays, 1 x Audit. Breast reconstructio paper submitted last week to HSCB.
SEC		DC	101	8	66	66	0	0.00%	-49					
SEC		IP/DC	400	33	262	227	-35	-13.36%	-13%	308	254	-54	-17%	
SEC	Endoscopy	IP	71	6	46	131	85	184.78%						29 x Nov sessions remaining x 6.5 patients, 101 x Dec sessions remaining x 6.5 patients = 845. Case for double procedures and other activity not currently including has been made which will improve SBA
SEC		DC	8005	667	5234	4811	-423	-8.08%	-305					
SEC		IPDC	8076	673	5280	4942	-338	-6.40%	-6%	6212	5787	-425	-7%	
SEC	ENT	NOP	8473	706	5540	5432	-108	-1.95%	-1%	6518	6317	-201	-3%	
		NOP (excluding SG)	7489	624	5041	5432	391	7.76%	8%	5761				
SEC		ROP	8642	720	5651	7741	2090	36.98%		6648				
SEC		IP	1238	103	809	758	-51	-6.30%		952				
SEC		DC	1290	108	843	1040	197	23.37%		992				
SEC		IPDC	2528	211	1652	1798	146	8.84%		1945	1998	53	3%	18 Session remaining x 3 patients = 54 Patients / 53 x Dec sessions x 3 patients = 159 = Total 213
SEC	General Surgery	NOP	8748	729	5720	5916	196	3.43%	3% (+147)	6729	6583	-146	-2%	122 NOP slots remaining in November and 545 NOP slots in December
SEC		ROP	11372	948	7436	5757	-1679	-22.58%						
SEC		IP	1451	121	949	873	-76	-8.01%						
SEC		DC	3469	289	2268	2405	137	6.04%						
SEC		IP/DC	4920	410	3217	3278	61	1.90%	1% (+42)	3785	3644	-141	-4%	76 elective remaining in November and 198 IP and 92 day cases for December (total of 290). Variance in endoscopy activity between clinical coding and specialty coding is included in GSUR specialty activity, hence such a variance in projections.
SEC	Opthalmology	NOP	3719	310	1954	1720	-234	-11.98%		Miss Twaij leaving Trust in December - overperformance will continue until that time. Visiting service after that time.				Mostly visiting service. SHSCT SBA overperforming for all areas. Underperformance overall due to SEHSCT underperformance. Ms Twaij leaving Trust in December.
SEC		NOP SHSCT	731	61	478	553	75	15.69%	16%					
SEC		ROP	7702	642	3965	3474	-491	-12.38%						
SEC		ROP SHSCT	1639	137	1071	1152	81	7.56%						
SEC		DC	991	83	457	317	-140	-30.63%						
SEC		DC SHSCT	292	24	191	269	78	40.84%	43%					
SEC	Orthodontics	NOP	542	45	354	250	-104	-29.38%						SBA for this year has not been revised. Awaiting Regional Dentistry Review.
SEC		ROP	3932	328	2571	1809	-762	-29.64%						
SEC	Orthopaedics (excluding ICATS)	NOP	1880	157	1229	1174	-55	-4.48%	-4%	1446	1366	-80	-6%	48 further NOP appointment slots remaining in November. 18 core clinics in December x 8 NOP = 144 NOP
SEC		ROP	2825	235	1847	1808	-39	-2.11%						
SEC		IP	642	54	420	404	-16	-3.81%						
SEC		DC	496	41	324	332	8	2.47%						
SEC		IP/DC	1138	95	744	736	-8	-1.08%	-1%	875	871	-4	-1%	24 further elective patients scheduled in November. 111 patients scheduled to December in core.
SEC	Trauma (Fracture clinic)	NOP	3944	329	2579	3339	760	29.47%						
SEC		ROP	7656	638	5006	5798	792	15.82%						
SEC	Urology (includes ICATS)	NOP	3949	329	2582	2246	-336	-13.01%	-13%	3038	2623	-415	-14%	Based on modelling of 05.11.13 and Suresh sessions
SEC		ROP	5405	450	3534	2741	-793	-22.44%						
SEC		IP	571	48	373	681	308	82.57%						
SEC		DC	4385	365	2867	1563	-1304	-45.48%						
		OPwP (TRUSB & Urodynamics)				340								
SEC		IP/DC	4956	413	3240	2584	-656	-20.25%	-21%	3812	3170	-642	-17%	86 further elective patients scheduled in November. December projections based on modelling of 05.11.13 and Suresh sessions

Received from Debbie Burns on 09/06/2023. Annotated by the Urology Services Inquiry.

SEC UPDATE

	NOVEMBER		DECEMBER		NOTES
	Access	SBA	Access	SBA	
Breast Surgery	25 weeks	-13%	26 weeks	-17%	5 lost lists in December
Endoscopy	11 weeks	-6%	11 weeks	-7%	Access will improve if permitted to include the queries raised. Extra volume of additionality requested to meet 9 weeks. Additionality for Q3 will be spent by end of November – Lynn has escalated to HSCB and clinicians on alert that sessions may be stood down. No patients have been sent for additional December sessions and risk with reasonableness therefore.
General Surgery New OPD	9 weeks	+3%	9 weeks	+2%	Lynn requesting return of 90 NOP additionality, sessions are in place, Lynn not anticipating a problem with this
General Surgery Elective	26 weeks	+1%	26%	-4%	This SBA December normally pulls up with the cases not included in endoscopy SBA
Ophthalmology NOP	25 weeks	-12%			SHSCT +15.69%. No December projections carried out as Miss Twaij leaving and this will become a Belfast problem
Ophthalmology Elective	13 weeks	-31%			SHSCT +41%. Washthrough from ISP much bigger in Q1&2 than anticipated. Q3 allocation spent with IS wasthrough – Lynn raising this risk
Orthopaedics NOP	13 weeks	-4%	13 weeks	-6%	We will be sitting on this SBA and hope to improve it . An extra 18 IH and 30 IS required to meet the 13 weeks – Lynn has requested this already and we the patients selected for IS and IH session organised.
Orthopaedics Elective	26 weeks	-1%	26 weeks	-1%	We have one complex patient of Mr Murnaghan to sort out which only he can do. There is one patient who is potentially not fit for surgery due to be seen next week and the complex patient will slot in here – complex patient has already accepted the date should this be the case.
ENT NOP	12 weeks	-1% 8% without 2nd staff grade			Problem with additionality in that audiology unable to cover the clinics and had late notice of this (yesterday), however, have since had agreement from Mr Hall that clinics will still go ahead but without patients requiring audiology. We have done a patient by patient check and removed any of these patients to replace with suitable, but chronicity may be affected.
ENT Elective	19 weeks	+8.84%	17 weeks	+3%	
Urology NOP	27 weeks ICATS 15 weeks Cons	-13%	22 weeks ICATS 15 weeks cons	-14%	Focus on LUTS during December to bring overall NOP access down
Elective	61 weeks	-21%	58 weeks		Working to -17% for December

Stinson, Emma M

From: Burns, Deborah [redacted]
Sent: 19 October 2012 15:23
To: Leyden, Francesca; Aljarad, Bassam
Cc: Simpson, John; McCooey, Blaithnid
Subject: sai [redacted] – [redacted]
Attachments: final report [redacted].doc; Dr B Farrell.docx SAI [redacted].docx

Importance: High

Hi all,
Following our meeting last Friday with the Board and Dr Farrell please find attached for your approval the amended SAI – CHANGES TRACKED ON PAGE 6 AND 18.
Also find attached separate cover letter – Dr Aljarad and Dr Simpson can you confirm you are in agreement with what we have stated in the letter in respect of actions Consultant1 has taken
Thanks D

Ps PLEASE RESPOND ASAP SO WE CAN SEND AND GET THIS ONE CLOSED

Debbie Burns
Assistant Director Clinical & Social Care Governance Trust Headquarters Craigavon Area Hospital
Tel: [redacted]
Email: [redacted]

Southern Health and Social Care Trust

Findings of a Root Cause Analysis Type Investigation Re – [redacted] SAI Reference [redacted]

CONTENTS

1 Introduction

Personal Information redacted by the USI's date of birth is Personal Information redacted by the USI and he died on Personal Information redacted by the USI aged Personal Information redacted by the USI. This report presents the findings of a root cause analysis (RCA) type investigation into the care and treatment provided to him when he was an in-patient on ward 3 North (paediatrics) at Craigavon Area Hospital (CAH) on Personal Information redacted by the USI, Personal Information redacted by the USI.

As Personal Information redacted by the USI died unexpectedly and had been treated in the Trust shortly before his death, it was felt appropriate to undertake an analysis of the care provided by the Trust.

The investigation was commissioned by the Chief Executive of the Southern Health and Social Care Trust (SHSCT).

2 Review Team Membership

The investigation team members were:-

Mrs Jacky Kingsmill, Liaison, Safety and Risk Manager for Children and Young People's Services (Chairman)
Dr Bassam Aljarad, Associate Medical Director for Children and Young People's Services, Consultant Paediatrician
Mrs Grace Hamilton, Head of Acute Paediatric Services

The team obtained assistance and advice from a number of other persons, including the medical and nursing staff who were involved in Personal Information redacted by the USI's care in CAH and in the Royal Belfast Hospital for Sick Children (RBHSC). The team were also informed by Personal Information redacted by the USI's mother and her advocate.

3 Terms of Reference for Review Team

The terms of reference set for the review team were:-

- To undertake a root cause analysis type investigation of the care provided to Personal Information redacted by the USI on Personal Information redacted by the USI when he was an in-patient in Craigavon Area Hospital.
- To use a multidisciplinary team approach to the investigation.
- To examine and evaluate the period of events between Personal Information redacted by the USI's arrival at Craigavon Area Hospital in the early hours of Personal Information redacted by the USI until his transfer to the Royal Belfast Hospital for Sick Children on Personal Information redacted by the USI.
- To make recommendations for improvement or learning.
- To report the findings and recommendations of the investigation to the Chief Executive.

4 Summary of Case

4.1 Episode of Care

Personal Information redacted was admitted to CAH by ambulance from his home. The ambulance was requested by his parents. It was mobilised at 0159 hours on Personal Information redacted by the USI, Personal Information redacted by the USI, arrived at Personal Information redacted's home at 0204, left the scene at 0220, and arrived at CAH at 0231 hours. Personal Information redacted was admitted to ward 3 North, via Accident and Emergency (A/E). Personal Information redacted remained on 3 North for approximately 35 hours until he was transferred to RBHSC at approximately 1320 hours on Personal Information redacted by the USI, Personal Information redacted by the USI. Personal Information redacted died on Personal Information redacted by the USI.

4.2 Stakeholders Involved

The main stakeholders involved in this review are as follows:-

- Baby Personal Information redacted, and his parents, Mr and Mrs Personal Information
- The nursing and medical staff at CAH

4.3 Chronology

The following table outlines the events in the episode of care under review:-

DATE	TIME	DETAIL
Personal Information redacted by the USI	0237	Arrived at CAH A/E via ambulance that had been mobilised 0159, arrived at Personal Information redacted's home at 0204, and left there at 0210. Staff nurse N1 met ambulance crew on arrival. Personal Information redacted's parents had reported that he had been unwell and deteriorating over the previous week. They reported that he was complaining of constipation and vomiting. At 0215 Personal Information redacted's pulse was recorded as 142; temperature 37.9, and oxygen saturations were recorded as 98.
"	0245 to 0310	Personal Information redacted was triaged in A/E by staff nurse N1. His observations were recorded including, urine, ECG and BM. He was given paracetamol because of his high temperature. He was examined by A/E doctor who recorded ?absence seizures?/ constipation and vomiting. It was noted that Personal Information redacted was stable but had a

DATE	TIME	DETAIL
		high BM and it was decided to admit him to paediatric ward. He was not seen by a paediatric doctor whilst in A/E.
"	0345-0350	Personal Information redacted by arrived on ward 3 north. He was not assessed but was immediately admitted to the bottom double sideward and the duty doctor was advised of admission
"	0400	Personal Information redacted was seen by nurse N5 who completed nursing admission assessment and documentation. N5 was immediately concerned regarding the dryness of Personal Information redacted's lips and mucus membranes. Oral fluids were offered and care was assigned to N5 for the remainder of the night shift. His observations appeared to be stable.
"	0430	Personal Information redacted by was seen by paediatric senior house officer, D4 in the side ward. D4 found it difficult to assess Personal Information redacted and so moved to him to the treatment room where on examination he was found to be very ill. D3 locum paediatric registrar was called to assess Personal Information redacted
"	0515	D3 examined Personal Information redacted and asked for the anaesthetist to attend. Personal Information redacted required resuscitation with boluses of fluids (total 30ml/kg). D3 discussed Personal Information redacted's care with consultant C1 who advised that he would attend. Portable x-rays were undertaken.
"	0632	Urinalysis was taken.
"	0900	1:1 nursing care was taken over by nurse N2. Personal Information redacted was described as very pale. Observations were recorded as GCS 7, HR 156, CRT 2-3 sec, temperature 37.8. Hourly observations taken throughout.
"	<0920	Personal Information redacted was seen by consultant C1 earlier than 0920 (not documented at the time but noted in chart by paediatric senior house officer D4). Urea: 8.2, Cr : normal.
"	0930	Personal Information redacted by was seen by paediatric locum registrar D3 who planned surgical review; ??obstruction and suggested USS ?. D3 and N2 were in communication.
	< 1015	N2 noted Personal Information redacted's abdomen to be distended. Abdominal girth measured and recorded.
"	1015	Note in chart - seen by consultant C1, allowed sips.

DATE	TIME	DETAIL
		Bilious vomiting documented.
"	1110	Note in chart by paediatric senior house officer D9, seen by consultant C1. Further fluid bolus's given. Bloods repeated. Working diagnosis dehydration.
"	1200	Note by nurse N2 concerned re NPU. ? surgical opinion required.
"	1300	Personal Information redacted was seen by surgical registrar D6 who suggested paediatric surgical opinion.
"	1410	Personal Information redacted by the USI was seen by paediatric registrar D7 who telephoned paediatric consultant C1: correct dehydration.
"	1412	Catheterised urinalysis: 1+ ketonuria.
	1815	Nurse N2 recorded: reviewed by consultant C1 due to frequent bilious vomiting.
"	2010	Nurse N2 recorded: had large bile vomit , described as pale and waxy, lethargic, HR 172 – Paediatric senior house officer D9 advised. 1:1 nursing care taken over from N2 by N4.
"	2345 re 2130	Retrospective note by paediatric registrar D5 to record bilious vomit at 2000 and NG tube inserted at 2130. Green bile draining from NG tube.
"	2200	Paediatric registrar D5 discussed Personal Information redacted with consultant C1 on phone. Continue current management. Change fluids.
Personal Information redacted by the USI	0130	Seen by paediatric registrar D5.
"	0620	Seen by paediatric senior house officer D4 as requested by nursing staff re apparent deterioration. ? perforation?
"	0730	Hourly nursing observations continue. Second surgical opinion planned.
"	not recor ded	Seen by surgical senior house officer who would discuss with surgical registrar.
"	0815 re 0630	Retrospective note – seen by paediatric registrar D7 at 0630 re deterioration. Planned surgical review.
"	0830	1:1 nursing care taken over by N6.
"	0830	Paediatric registrar D7 advised Consultant C1 of 0815 note re 0630 examination. C1 advised decrease fluids to maintenance.

DATE	TIME	DETAIL
"	0845	Seen by paediatric senior house officer D4.
"	0845	Surgical review by surgical registrar and house officer. Bilious output. Needs transfer to RHCSC for further investigation and management. Cannot exclude intussusception/perforation.
"	< 0900	C2 recalls a telephone conversation with C2 about the need for radiological examination in which C2 advised that such examination could be arranged immediately. This is not recorded in the notes.
"	0910	1:1 nursing care temporarily taken over by nurse N3 – CEWS score = 9 note by nurse N3 that Personal information redacted seen by Consultant C1 who requested USS and surgical assessment.
"	0945	Accompanied to X-Ray by paediatric senior house officer D2 and nurse N6.
"	1020	Seen by Consultant Radiologist C2 . USS completed and progressed to CT scan. Primary diagnosis of volvolus with necrotic wall, free air and fluid ++ requires surgical intervention.
"	1100	Returned to 3N, assessed for transfer by anaesthetic team.
"	1115	Planned transfer from 3N to theatre for intubation and transfer to Belfast.
"	1145	Nurse N6 noted:- more drowsy since CT scan etc. Parents spoken to by Consultants C1 and C3 to advise of planned intubation, ventilation and transfer. Handover to theatre staff completed.
"	1200	Admitted to CAH theatre.
"	1215	Note by Nurse N6: re bolus etc.
"	1245	Note by Nurse N6 intubation and ventilation complete and parents updated.
"	1310	Left CAH theatre for Belfast.
"	1350	Arrival at RBHSC.
"	1430	Note re transfer to the paediatric intensive care unit at RBHSC - stable during transfer.

4.4 Relevant Past History

Personal Information redacted had previously been known to C1 for management of constipation. He was also known to Trust staff in the Child Development Clinic for management of his Personal Information redacted by the USI.

4.5 Outcome, Consequences and Action Taken

When Trust nursing staff learned of the unexpected death of Personal Information redacted, they reported to the Liaison, Safety and Risk Manager (LSRM) who immediately arranged for notes and records to be secured pending the consideration of any necessary investigation. LSRM discussed the matter with the Director of Children and Young People's Services and the Assistant Director of Specialist Child Health and Disability and obtained direction that a review of care was prudent. Terms of reference for the review were set and membership of the review team confirmed. The Director of Children and Young People's Services discussed the matter with the Trust's Chief Executive and Medical Director.

The LSRM had been advised that C1 had been in discussion with Personal Information redacted's parents about the management of his care at Craigavon Area Hospital and understood that C1 had offered to meet with the parents. The review team therefore decided not to make contact with the parents immediately in order not to intrude further on their grief. Personal Information redacted's parents subsequently wrote to the Trust in Personal Information redacted by the USI and his mother and her advocate met with the review team in Personal Information redacted by the USI.

This review was considerably delayed for a number of reasons. ~~including difficulties in arranging dates for review team members to meet, and because of pre-arranged leave arrangements. It was further delayed because of the diversion of review team members to planning duties in connection with pandemic influenza.~~ The delay is regretted most sincerely and the impact of the delay on Personal Information redacted's parents and the staff involved in his care is acknowledged.

It was felt that the RBHSC would have reported Personal Information redacted's death to the Department of Health, Social Services and Public Safety (DHSSPSNI) as an incident because it was an unexpected child death occurring shortly after surgical intervention. In Personal Information redacted by the USI, the LSRM received confirmation that the death had not been notified to DHSSPSNI as an incident and so she notified it retrospectively on Personal Information redacted by the USI.

5 Methodology for Investigation

The investigation was based on best practice associated with the National Patient Safety Agency's "Seven Steps to patient Safety"[1] and Maria Dineen's "Six Steps to

[1] National Patient Safety Agency: Seven Steps To Patient Safety, An overview guide for NHS staff, Second print April 2004

Root Cause Analysis" [2]. The processes associated with these approaches are documented in the following sub-sections.

The team met on approximately ten occasions and in addition they conducted work electronically and by telephone. Members of the team liaised with the Coroner's office, RBHSC staff, and staff based at CAH who were involved in Personal Information redacted's care during the admission under review.

5.1 Review of Records

The investigation team reviewed the following records:-

- Personal Information redacted's CAH medical and nursing notes
- Personal Information redacted x-ray films and records
- Clinical summary of care from RBHSC
- Extract from the Northern Ireland Regional Perinatal/Paediatric pathology Service Post-mortem report re Personal Information redacted.
- Extract from CAH Surgical Morbidity and Mortality Notes Personal Information redacted by the USI [redacted]

5.2 Review of Staff Statements

All staff who were involved in Personal Information redacted's care participated in face to face discussions with review team members. Key staff have been given an opportunity to review the team's report in draft form for factual accuracy.

5.3 Relevant Standards, Reports, Policies and Procedures

The team considered the following reports, standards, policies and procedures during the investigation:-

- Good Medical Practice, GMC 2006
- NMC Code
- Standards of conduct performance and ethics for nurses and midwives
- NMC Guidance for nurses and midwives

5.4 Carer Involvement

The review team met with Personal Information redacted's mother and her advocate on Personal Information redacted by the USI and have been in liaison by letter since that date to update on progress and the unfortunate delays in finalising this review. Personal Information redacted's parents have been invited to review a draft of this report to ensure its factual accuracy and to establish if there is anything they would wish to add that has not been included.

[2] Maria Dineen, Six Steps to Root Cause Analysis, Consequence UK Limited, 2004

The review team very much appreciate the contact made by Personal Information redacted's parents and the very open and frank discussion they had with Personal Information redacted's mother and her advocate.

At the meeting, team members extended their heartfelt sympathy to the family and those condolences are offered here once again.

Although team members cannot fully contemplate the effect that Personal Information redacted's death has had on his family, they appreciate the distress suffered by all of his relatives and carers. It is clear to team members that Personal Information redacted was a very special and cherished child whose loss will have been most significantly felt by his family.

The team recognise the right of Personal Information redacted's family to pursue all avenues of redress and enquiry, including litigation.

Review team members would wish that all possible assistance, support, and information be provided to Personal Information redacted's parents.

The pertinent question for Personal Information redacted's parents concurs with that of the staff involved and with members of the review team which is:-

Would the death of Personal Information redacted been avoided, or any pain and discomfort he suffered been relieved, if he had been transferred to RBHSC for specialist paediatric advice and necessary treatment sooner than when he was?

Personal Information redacted's parents also wished to know if he had been treated less favourably or differently because Personal Information redacted by the USI ***.***

6 Analysis

This section provides a summary of the analysis undertaken by the review team. The analysis informs the conclusions and recommendations made in section 7 of this report.

6.1 Treatment and care

The review team found good evidence that Personal Information redacted received a lot of attention from both nursing and medical staff whose efforts to provide him with care of a high standard were significant. This was evident from the notes made and from discussions with the review team. There were good examples of cross speciality cooperation between anaesthetics, surgery and radiology.

C1 was the consultant paediatrician leading the management of care for Personal Information redacted during this episode. He is a fully qualified and experienced clinician who has worked in

CAH for many years. He is fully familiar with policies, procedures and protocols in place for management of paediatric medicine both within CAH and outside that facility.

The review team were disappointed to note that some nursing and medical staff seemed to be frustrated that concerns raised, particularly with consultant C1, were not fully considered and that they had no mechanism to convey ongoing concern with other senior staff for fuller discussion.

There are multidisciplinary records in use within paediatrics in CAH however, there was evidence that some members of staff paid insufficient attention to the notes made by other members of the multidisciplinary team. The review team are disappointed by this and find that it defeats the purpose of making and using multidisciplinary records.

The review team found evidence of discrepancies in the assessment of Personal Information redacted's condition during the day of Personal Information redacted by the USI. Most of the staff attending to Personal Information redacted felt that whilst he was a very sick child, he had shown some initial improvement following administration of a fluid bolus. However, during the following hours he remained quite sick with no evidence of improvement. The review team feel that the diagnosis of dehydration that was initially made by C1 set the tone for the rest of Personal Information redacted's care management. It is the opinion of the review team that although such a diagnosis was reasonable at the start of the episode of care, it should have been reviewed in light of the lack of an explanation or any cause for dehydration, the development of important signs like the distended abdomen, the bilious vomiting, and that Personal Information redacted remained sick despite fluid management. Personal Information redacted continued to have persistent tachycardia, pallor, and was lethargic. It is the view of the review team that these signs were not in keeping with the degree of dehydration evidenced by urea of 8.5 and 1 plus of ketones.

The review team found it of most significance that, although there were records of bilious vomiting made by staff, in their discussions with C1, he advised that he was not aware of any bilious vomiting. There were a number of records to confirm that Personal Information redacted was assessed frequently by consultant C1, however, there were no personal notes made in the records by C1. There were a number of entries made on his behalf.

C1 advised the review team that, in his experience, both radiological investigation and specialist paediatric surgical opinion were difficult to obtain during weekend periods. In discussion with the review team, C1 advised that he felt that Personal Information redacted's condition had been getting better during the day of Personal Information redacted by the USI. He acknowledged that Personal Information redacted's presentation was difficult and that the eventual diagnosis of “Meckel’s Bands” was rare. He stressed that, if at any time he had thought that Personal Information redacted was in pain, he would have arranged radiological assessment or referred him to RBHSC earlier than when he did. He had considered an alternative diagnosis of

appendicitis. It remained his opinion that Personal Information redacted was suffering from dehydration until the morning of the Personal Information redacted by the USI, around 0800 hours, when a perforation was evident. He recalled that, prior to that, he had last seen Personal Information redacted by around 1800 hours on Personal Information redacted by the USI. C1 felt that on Personal Information redacted by the USI around 0800 hours, Personal Information redacted's presentation had changed. At that time he found that Personal Information redacted's abdomen was distended. C1 immediately arranged for radiological examinations and the subsequent transfer to RBHSC ensued. After reflection, and with the benefit of hindsight, C1 felt that it may have been prudent to react more speedily and perhaps have arranged an earlier transfer to RBHSC for urgent specialist paediatric surgical opinion. However, he had felt at the time that there had been no indication for seeking earlier radiological examinations given that he had found that the abdomen was soft and not tender.

C1 expressed to the review team, his regret about the outcome of care provided to Personal Information redacted and advised that he had also made that expression to Personal Information redacted's parents. He concluded that, at the time, he felt he had not had enough evidence prior to 0800 hours on Personal Information redacted by the USI, to agree the transfer of Personal Information redacted to RBHSC and that following consideration of the episode of care and with the benefit of hindsight, he could see how it may be perceived that he may have made an error of clinical judgement. He felt that he used his best clinical judgement at the time given all of the information he had available at the time. His opinion remains that Personal Information redacted would not have been in pain from peritonitis but that he might possibly have been suffering from chronic pain from the rare condition of "Meckel's Bands" which he would have had for some considerable time.

Personal Information redacted's mother described to the team how she felt that her son was in pain. She described him squirming when examined, and that she and Personal Information redacted's father who obviously knew him best, knew that his presentation was very different from normal and that he was unresponsive. She felt that C1 spoke to her abruptly when he first examined Personal Information redacted and that he stated in an unacceptable manner *"what has happened to this child, ... he is malnourished and dehydrated"*. She felt that C1 was dismissive of her and did not listen to concerns that she raised nor her pleas that Personal Information redacted was in pain. She reported that when C1 examined Personal Information redacted's stomach, he did so roughly and said that there was nothing wrong with him. She explained that she felt Personal Information redacted's tummy was getting bigger sideways rather than upwards and how he was "absent" or "not there". She said that she knew from his eyes that he was in pain. She described how there was green vomit staining on his pillow.

Personal Information redacted's mother commended the nursing staff in ward 3 north, the ambulance staff, and the staff in CAH A/E department as well as staff at RBHSC, all of whom she felt were responsive, caring, and informative.

The review team noted from the RBHSC clinical care summary that on arrival at RBHSC, staff there performed an immediate laparatomy and found a volvulus secondary to congenital Meckel's Bands, and a necrotic small and large bowel. Personal Information redacted

had post-operative hypotension and metabolic acidosis, electrolyte disturbance and coagulopathy. He had renal impairment that led to oedema. His hypotension increased and despite ongoing treatment, he unfortunately died on Personal Information redacted by the USI, Personal Information redacted by the USI.

6.2 Review

The review of this episode of care was significantly delayed because staff appointed as review team members were firstly not available to meet on an early date because of leave arrangements and then were subsequently assigned other duties. There were also delays in obtaining information from RBHSC to inform the review team. This has had a negative effect from a number of aspects including assisting to provide answers for Personal Information redacted's family; effecting "closure" for staff; providing the Trust with assurances regarding provision of care; and, effecting recommendations and actions. The delays are regretted and the concerns of the family and of staff are fully appreciated.

The Trust operates governance arrangements on the basis that staff are expected to be open and honest and to co-operate with all investigations. Staff involved in this investigation appreciated this arrangement and contributed to the review. Most staff did so in the spirit expected. Those staff who were hesitant in any way were offered all necessary support. It was evident from discussions with staff how touched they have been by the death of Personal Information redacted and how emotional it remains for them to discuss their involvement in his care. The review team fully appreciate how difficult it is for staff to have their work and records scrutinised in such detail and thank them for their co-operation. The review team discussed support and any assistance necessary with all staff who were involved. All reported availing of peer support although no formal debriefing appears to have taken place immediately after Personal Information redacted's death.

The review team also appreciate how difficult it was for Personal Information redacted's mother to contribute to the review. They regret that they had not been in contact prior to the family writing in June, 2008. The review team had not made contact earlier because of their understanding that C1 had been in touch and offered to meet and of their wish not to further intrude on the family's grief. Personal Information redacted's mother advised that C1 had been in contact with her by telephone on the day of Personal Information redacted's death and, understandably, the family did not wish to engage at that time. She had hoped however, that someone from the Trust would have been in touch again sooner without her having the need to instigate further contact. She had not been given any detail of how to engage with the LSRM about further liaison or enquiry. She understandably felt that there would have been no contact with her had she not initiated it.

The review team noted the record of discussion at the Personal Information redacted by the USI surgical morbidity and mortality meeting that although the surgical opinion around lunchtime on Personal Information redacted by the USI was to transfer, a decision was made on the ward by the medical

paediatric team not to transfer. It is noted in the record of this meeting that a clinical incident form had been completed and forwarded, however, the LSRM has not received such a report. As far as the review team can establish, there was no representative from paediatrics at this meeting. C1 and C2 are noted as being in attendance at the Personal Information redacted by the USI meeting of the same group. It was recorded incorrectly in the note of that meeting that the notes pertaining to this episode of care for Personal Information redacted by the USI were with the Coroner.

6.3 Summary of Analysis

The following summarises the analysis offered by the review team and includes issues that the team felt were both positive and negative and also those that did not directly affect the care provided to the patient but that are highlighted by way of observation and to assist learning.

6.3.1 Patient and other Individual's Factors

The patient was a young and sick child Personal Information redacted by the USI whose presentation was therefore difficult for staff to fully assess. However, the team found that staff took cognisance of this and were aware of the need to exercise additional awareness and provide good monitoring.

The patient had fluctuating periods of wellness and improvement during the early hours of this episode of care.

The patient's parents report that one or other of them or another relative who knew the patient well, remained with the patient at all times except when they were asked by staff to leave for a particular reason.

There was good evidence that nursing staff listened carefully to and interacted well with the patient's parents who knew the child well.

Unfortunately the patient's mother is of the view that C1 did not listen to her.

6.3.2 Task Factors

There was good evidence that Trust staff remained with the patient on a one to one basis for almost all of the episode of care.

Fluid balance charts were well completed by nursing staff.

There is evidence to suggest that when C1 made up his mind on the diagnosis, he appeared not to take sufficient cognisance of the clinical judgement of others on the team. It appears that C1 felt that Personal Information redacted by the USI was improving when other members of the clinical team and Personal Information redacted by the USI's parents thought he was not. It is the view of the team

that C1 should have fully considered the views of others and re-evaluated his early diagnosis as the clinical picture changed. As C1 seemed to be unaware of the presence of bilious vomiting, it appears that he did not routinely review notes made by other members of the multidisciplinary team.

In discussion with the review team, C1 reported his experience that transfer to RBHSC is notoriously difficult without sound evidence of clinical need.

There was evidence that the "early warning" observation score was well completed, however, some staff were unfamiliar with use of this system and reported not availing of training for using it.

Nursing staff were using both a head injury chart and the early warning system chart which was inappropriate as there was no head injury evident and was a duplication of effort.

There was evidence of good record making by the majority of staff, however, there were clearly gaps in recording, particularly by C1 who, although frequently in attendance and giving advice, as evidenced in the recording of others, did not make sufficient notes.

There was no contemporaneous record of treatment provided by anaesthetic medical staff and theatre/recovery nursing staff who intubated and stabilised the patient in readiness for transfer. It is accepted however that concentration in this regard was on providing the urgent care needed at that time and that the original notes were not available to theatre staff after care had been provided as they went with the patient on transfer. The review team has requested that a retrospective record be made.

The nursing care plan was not updated to reflect the patient's needs and level of care provided.

Upon transfer from A/E to the ward, there was no recorded evidence of good handover or communication about the patient's condition or state of dehydration. There was also no evidence of an assessment that led to the allocation of an appropriate bed space on the ward.

The signature chart required in case notes was not well used by nursing and medical staff.

6.3.3 Communication Factors

The patient's parents report that nursing staff communicated well with them and with the patient as far as was possible.

When the decision was made to obtain a radiological opinion and subsequently effect a transfer to RBHSC, there is good evidence of sound communication between all parties.

The patient's parents report that C1 did not communicate with them appropriately and that he was abrupt and dismissive toward them.

There is clear evidence of communication failures within the clinical team with both nursing and medical staff feeling that C1 did not welcome their communications.

C1 reported a lack of radiology support at week-ends although C2 reported a presence in the hospital during all of the week-end of the episode of care. It may be that C1 was unaware of that presence and based his view on previous experience of seeking radiological support.

6.3.4 Team and Social Factors

There appears to be evidence of a dysfunctional team approach to the care of Personal Information redacted. In addition, a suitable alternative senior member of staff was not identified for team members to consult with when differences of opinion arose or when their individual clinical opinion appeared not to have been adequately considered.

When the decision was made to obtain a radiological opinion and subsequently effect a transfer to RBHSC, there is good evidence of sound teamwork to effect a transfer that is considered timely and well undertaken by all members of a number of teams working well together.

There is good evidence that when CAH paediatric staff wished a surgical opinion, it was speedily provided (on two occasions). Similarly, when assistance was requested from anaesthetic staff (again on two occasions), that was speedily provided.

6.3.5 Education and Training Factors

There was evidence to suggest that not all staff had availed of training regarding use of the early warning observation system.

Whilst the early warning system was used for monitoring, it was not used to alert staff to the patient's deteriorating condition.

6.3.6 Equipment and Resource Factors

The review team found no evidence, either positive or negative, with regard to equipment or resource factors that affected the care provided in this episode. It

was noted however, that medical staff were extremely busy during the week-end providing cover to the paediatric ward as well as the maternity and neo-natal units.

6.3.7 Working Conditions Factors

The review team found no evidence, either positive or negative, with regard to working condition factors that affected the care provided in this episode.

6.3.8 Organisational and Strategic Factors

It is unfortunate that the parents of the patient had to take the initiative in making contact with the Trust to have their understandable questions aired.

Staff reported a lack of feedback from RBHSC following transfer and that they only learned of the death of this patient when they telephoned informally to enquire about his progress.

The review team did not find sound evidence that, following the death of this patient, staff were immediately provided with all necessary care and support including de-briefing at the time.

7 Conclusions, Learning and Recommendations

7.1 Conclusion

With regard to the pertinent question posed both by Personal Information redacted's parents and the review team:-

Would the death of Personal Information redacted been avoided, or any pain and discomfort he suffered been relieved, if he had been transferred to RBHSC for specialist paediatric advice and necessary treatment sooner than when he was?

The review team conclude that earlier transfer to RBHSC from CAH may not have ensured that Personal Information redacted's death could definitely have been avoided. Although Personal information redacted by USI" is a rare congenital condition that might not have been easily diagnosed prior to surgery, the presence of bilious vomiting and a distended abdomen in a sick child should have alerted clinical staff to the need for further investigations and advice from regional specialists. The team therefore concludes that transfer should have been arranged earlier following review by CAH surgical staff around lunchtime on Personal Information redacted by the USI (approximately 24 hours earlier than the actual transfer). Earlier transfer may have assisted in ensuring the alleviation of any pain and suffering Personal Information redacted may have been experiencing and would have ensured that a robust specialist paediatric surgical opinion was obtained at an earlier stage.

It would also have assisted in maintaining the confidence of Personal Information redacted's parents in the care provided at CAH and them being less critical in their perception of C1.

With regard to Personal Information redacted's parents wish to know if he had been treated less favourably or differently because he was a child with Personal Information redacted by the USI, the review team conclude categorically that Personal Information redacted was not less favourably treated. All staff in discussion with the review team displayed awareness of the particular needs of the sick child Personal Information redacted by the USI and were cognisant of providing additional attention and monitoring.

7.2 Learning

The investigation team has concluded that there are a number of points of learning following review of this episode of care including clinical judgement and diagnoses, team working and communication, liaison with and listening to parents of sick young children, record making, use of multidisciplinary records, support for staff, and timeliness of reviews. A number of recommendations are made in this regard at 7.1 below.

7.3 Recommendations

7.3.1 Local Recommendations

The review team recommend that:-

7.3.1.1 the Trust writes officially to the parents of Personal Information redacted to express their regret that there were aspects of this episode of care that were less than exemplary and that, with the benefit of hindsight, it may be that an error of clinical judgement may have been made in not arranging for Personal Information redacted to be transferred earlier for a specialist paediatric surgical opinion. The correspondence should also include an offer to provide any further assistance, information and support that the family require.

7.3.1.2 C1 is afforded the opportunity to develop improved communication skills regarding interactions with patients, carers, and colleagues.

7.3.1.3 paediatric medical and nursing staff are provided with further training on the use of early warning observation systems.

7.3.1.4 paediatric medical and nursing staff are reminded of the need to make and use records appropriately including use of the signature chart and that they read records made by other members of the multidisciplinary team.

7.3.1.5 A policy should be developed for all paediatric and neo-natal wards providing clinicians of any discipline with a mechanism for further

consideration of differences of clinical opinion, and where agreement is not reached, the mechanism for second consultant opinion to be obtained.

7.3.1.6 that paediatric nursing and medical staff are reminded to record any stated difference in clinical opinion and the resultant decision or action taken.

7.3.1.7 the Children and Young People's Directorate ensure that arrangements are in place for debriefing staff following an unexpected death or incident and ensuring that staff are made aware of all supports available to them in such an event.

7.3.1.8 that all staff within the Trust in all departments are reminded of the importance of listening to the opinion of colleagues and, most importantly, the views of patients and/or their carers who know them best.

7.3.1.9 that consideration is given to improving the timeliness of reviews of this type, even in the current resource climate, in order to assist patients, carers, and staff.

7.3.1.10 that all records used in this review are returned appropriately.

7.3.1.11 that the notes of the surgical morbidity and mortality meetings of Personal Information redacted by the USI are corrected.

7.3.1.12 all Trust staff who treat children and young people undertake training in use of early warning monitoring systems.

7.3.1.13 that a retrospective theatre/anaesthetic note of care given to Personal Information redacted prior to transfer on Personal Information redacted by the USI is made.

7.3.1.14 that all Trust staff are reminded of the role of LSR managers and that any patients, carers, or clients who raise issues should be given contact details for the relevant LSR manager.

7.3.1.15 that all trust staff are reminded of the need to complete incident record forms appropriately.

7.3.1.16 that an action plan is developed to ensure that the recommendations of this review (including regional recommendations) are effected as early as possible if arrangements have not already been put in place.

7.3.2 Regional Recommendations

7.3.2.1 Although in this case there was no issue of delay in either receiving a specialist paediatric opinion or in the acceptance of RBHSC to receive the transfer, ~~T~~the review team recommend that a regional evaluation ~~or audit~~ of liaison between "district general hospitals" and RBHSC as the regional centre of excellence with regard in particular to

7.3.2.1.1 obtaining specialist paediatric opinion, and
7.3.2.1.2 criteria for accepting transfers

is undertaken with a view to ensuring that appropriate and timely advice and support is readily available for clinicians working in "outlying hospitals". The team are aware that this issue will be dealt with during the current regional review of paediatrics.

7.3.2.2 The review team would advocate ~~wish to see that there is~~ a more formal system ~~in place~~ for staff to obtain feedback on paediatric patients transferred to RBHSC with a view to improving learning and increasing good liaison between regional specialists and local clinicians and providing support to local staff.

The team are aware some actions have already been put in place in respect of some of the recommendations made above.

Dr B Farrell,

Public Health Consultant & DRO

PHA

ETC ETC

Dear Dr Farrell,

RE: Personal Information redacted by the USI SHSCT

Further to our recent meeting of 12th October 2012, I am writing to confirm that Consultant 1 has undertaken further training in communication skills as outlined in the recommendations. I would also wish to confirm that this Consultant appeared before the GMC in relation to this case and was exonerated of any clinical practice issues. The issues arising from the incident have also been discussed with Consultant 1 during appraisal and at various separate times.

I trust that this confirmation together with the amended SAI report (amendments made to page 6 and 18) will enable this SAI to be closed.

Yours sincerely

Deborah Burns

Assistant Director CSCG

Stinson, Emma M

From: Burns, Deborah <[redacted]>
Sent: 25 April 2013 17:09
To: Marshall, Margaret
Subject: FW: Baby [redacted] - ammended final going to smt
Attachments: v9 report (agreed by CYP SMT) 18 04 12.doc

FOR SMT

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

From: Burns, Deborah
Sent: 25 April 2013 17:09
To: Morrison, Denise
Subject: Baby [redacted] - ammended final going to smt

Hi Denise
Please find attached - I have accepted the vast majority of the change from CYP management – this is the vewsion I am sending to Margaret for smt next Wednesday can you let Paul etc know and for your records

Thanks
D

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: [redacted]
Email: [redacted]

Southern Health and Social Care Trust

Quality Care - for you, with you

SERIOUS ADVERSE INCIDENT REPORT

BABY Personal Information redacted by the USI

D.O.B: Personal Information redacted by the USI

D.O.D: Personal Information redacted by the USI

ID: Personal Information redacted by the USI

HSCB: Personal Information redacted by the USI

CONTENTS

1.0 Introduction

This is the Southern Trust's Serious Adverse Incident report in relation to the death of Baby [redacted] on [redacted]

2.0 Team Membership

Mrs Debbie Burns	Assistant Director of Governance (Chair)	SHSCT
Dr Cathy Macpherson	Independent Consultant Paediatrician/Named Doctor for Child Protection	SEHSCT
Mrs Grace Edge	Lead Nurse Paediatrics. Independent paediatric Nurse.	NHSCT
Dr Robert Carlile	Clinical Lead for GP Out of Hours Service	SHSCT
Dr James Hughes	Consultant Paediatrician and Named Doctor Child Protection	SHSCT
Mrs Grace Hamilton	Head of Acute Paediatric Services	SHSCT
Mrs Julie McConville	Head of Health Visiting & School Nursing	SHSCT
Dr Karen McKinney	Consultant Obstetrician (carried out a note review of the Obstetric history)	SHSCT
Ms Patricia McStay	Head of Midwifery	SHSCT
Mr Paul Kerr	Consultant Emergency Medicine	SHSCT
Ms Francesca Leyden	Assistant Director Social Work Governance	SHSCT

The Assistant Director of Family Support and Safeguarding was initially part of the review team, however during the review it was apparent that on [redacted], after Baby [redacted] had been discharged, that they had a decision making role. Therefore the Assistant Director of Family Support and Safeguarding stood down from the review. This involvement is detailed in Section 5.1.8.

To ensure safeguarding expertise was available to the review team Ms Donna Murphy, Principal Practitioner for Child Protection joined the group prior to the report being signed off.

3.0 Terms of Reference of Investigation/Review Team

1. To undertake a review into the care, treatment and intervention provided to Baby Persona l Informati.

2. To collate a timeline to outline the sequence of events in the context of multi-disciplinary involvement with baby Persona l Informat. This timeline and scope of the review will include antenatal and post natal care, together with new born care provided by both primary and secondary care.

3. To use a multi-disciplinary team approach to the review supported by Independent Advisors.

4. To provide an agreed chronology based on documented evidence and staff accounts of the events leading up to and including Baby Persona l Informat admission to ED on Personal Information redacted by the USI as defined above in the scope.

5. To identify the key factors and events which may have influenced or contributed to the readmission and subsequent death of Baby Persona l Informati.

6. To set out the findings, recommendations, actions and lessons learned from this case.

7. To report the findings and recommendations of the review through the Director of Children and Young Person's Directorate, Director of Older People and Primary Care, the Director of Acute Services and the Trust Senior Management team.

8. To provide an agreed action plan to operationalize findings and recommendations.

9. To provide a Serious Adverse Incident Report to Health & Social Care Board and HM Coroner.

4.0 Methodology for Investigation

The review team followed a route cause analysis methodology through the following process:

- Review team meetings were held on Personal Information redacted by the USI and Personal Information redacted by the USI.
- Review of patient / service user records by all relevant healthcare professionals involved in this baby's care.
- Photographs of the presenting bruises were available to the review team.
- Development of chronologies of care and analysis of information.

- Meetings were carried out with all professional staff.
- Compliance with Regional and Trust policies and procedures were analysed.

5.0 Summary of Incident/Case

The health visitor made a pre-arranged home visit on the [redacted] to carry out Baby [redacted]'s [redacted] health review. Baby [redacted]'s Mum reported that she was feeling well and continued to have good support from her husband and extended family. Prior to health visitor asking mum to undress [redacted] she lifted him onto her knee and then drew the health visitor's attention to the bruising. Mum showed the health visitor bruising on his right leg, on the outer calf and upper thigh. The health visitor examined [redacted] and he did not present as being in pain or discomfort and had full range of movement of his legs. Mum advised that she had noticed it the previous night in the bath and was not sure if he had hit his leg off the bath or if baby sling or baby bouncer had caused it. [redacted] appeared well and was alert and vocalising during the visit. Baby [redacted] was due his third set of immunisations that afternoon at an Immunisation Clinic in the GP Practice. The health visitor advised Mum that she needed to have [redacted] examined by the GP for assessment of the bruising prior to his immunisation being administered. The health visitor also observed slight asymmetry in skin creases on [redacted]'s legs and Mum was advised to consult with GP. The health visitor advised that she would make contact with her following attendance at the GP.

Mum attended Family GP for Baby [redacted] routine vaccinations on [redacted] and drew the GP's attention to the bruising. She did not indicate to her GP any involvement with the Health Visitor earlier that day. Following advice from the Staff Grade Paediatric Ambulatory service, the GP referred Baby [redacted] to the Acute Paediatric ward for assessment of the bruising

Baby [redacted] was admitted to the Paediatric Children's Ward on [redacted] due to the unexplained bruising and was allowed home the same evening as a suspended admission, to be reviewed the following morning. A follow up medical review of Baby [redacted] was completed at the Paediatric Children's Ward on [redacted] and he was discharged with no further paediatric medical review. The Paediatrician requested that the Health Visitor carry out a follow- up home visit on return from her annual leave which was would have been planned for the week commencing [redacted].

Baby [redacted] was later admitted to the Emergency Department CAH by Ambulance as an emergency following seizure activity at 03:40 hours on [redacted]. He was stabilized and moved to Paediatric Ward with an initial possible diagnosis of meningitis. Investigations on admission noted that his haemoglobin had dropped significantly to 7g/dl. His fontanelle was bulging and his eyes were noted to be sunset. A CT scan showed significant intracranial haemorrhages Baby [redacted] was intubated and transferred to the Regional Paediatric Intensive Care Unit. No medical explanation was determined nor was there any explanation from his parents. PSNI and Out of Hours Social Work Service were notified.

At this stage, the clinical findings raised the possibility of a non-accidental Injury. The parents were subsequently interviewed by PSNI and Social Services under Joint Protocol proceedings. Baby Persona l Informati remained unstable, receiving intensive care.

Baby Persona l Informati subsequently died on Personal Information redacted by the USI.

A post mortem skeletal survey did not reveal any bony injuries.
The neuropathology results of the post mortem were not available to the review team and remain outstanding.

There has been no previous history of social work involvement with this family. A notification form for Potential Case Management Review was completed and submitted to the Safeguarding Board Northern Ireland (SBNI) on Personal Information redacted by the USI. The Trust has provided frequent updates to the SBNI and the decision to proceed to a Case Management Review will be taken following the publication of this serious adverse incident report and the post-mortem results.

Key to Professionals involved:

Dr 1	Consultant Paediatrician (Baby Persona l Informati 's Consultant of the Week)
Dr 2	Consultant Paediatrician (Consultant on Duty on 27.11.12)
Dr 3	Consultant Paediatrician (Trust Designated Doctor for Child Protection)
Dr 4	Staff Grade (Ambulatory Unit)
Dr 5	Consultant Paediatrician
Dr 6	Consultant Paediatrician
Dr 7	Paediatric Registrar
Nurse 1	Staff Nurse
Nurse 2	Advanced Nurse Practitioner
Nurse 3	Deputy Ward Sister
Nurse 4	Deputy Ward Sister
Nurse 5	Senior Staff Nurse
CPNS	Child Protection Nurse Specialist
HV	Health Visitor
GP	General Practitioner

5.1 Chronology of Events and Analysis of these Events

5.1.1 Obstetric Care

As part of the review into the care that Baby [redacted] received a Consultant Obstetrician and the Head of Midwifery reviewed the records from Mum's booking to her postnatal discharge. This review highlighted a straightforward forceps delivery of Baby [redacted] on [redacted] at 01:08 hrs with Apgar scores of 8@1and 9@5 minutes. A Paediatrician was present for the delivery. The review team was able to conclude that the baby was not affected by the forceps delivery.

5.1.2 Health Visiting

The review team undertook a review of health visiting records and interviewed the Health Visitor involved with baby [redacted].

Throughout the HV's involvement with Baby [redacted] and his Mum there were no concerns about her care of [redacted] or about [redacted]'s physical and emotional development. Mum appeared to be an attentive parent who was receptive to health visiting advice. Mum appeared to be proud of [redacted]'s milestones. The home environment was baby friendly and photographs of him were present.

It was confirmed during interview that the HV had no previous contact with Baby [redacted]'s father. The HV confirmed that Mum reported that she had a supportive husband and that she had good family support. There were no disclosures regarding domestic abuse on routine enquiry for domestic violence in the postnatal period.

The HV telephoned Mum on [redacted] to arrange to visit on [redacted] to complete the [redacted] core health review contact during the visit on the [redacted]. Mum was relaxed and interacted positively with [redacted] which he was responsive to – smiling, laughing and gurgling.

Following discussion about [redacted]'s health, weaning, play and stimulation and prior to mum being asked to undress [redacted] for growth measurement, mum lifted [redacted] onto her knee and drew health visitor's attention to the bruising. . Mum advised the HV that she noticed the bruising when bathing [redacted] the previous evening ([redacted]). The HV advised during the interview carried out as part of the review that Mum showed genuine concern but was not anxious about the bruises. Mum provided possible explanations for the cause of the bruises, (1) baby harness, (2) baby bouncer.

During the interview the health visitor advised that mum felt the bruising could possibly have been caused by the baby harness during a walk at [redacted] on Sunday where [redacted] had been strapped to his dad in the harness.

The HV reviewed the bouncer in the hall and asked Mum from what age its use was recommended for and was advised it was suitable from 3 months. The HV considered this was not a likely explanation for the bruising.

During interview the HV described the bruises "light bruising in an unusual position, didn't look like a handmark" and in the health visiting record the bruising is described as 'light bruising to outer aspect of right calf and little more on the thigh not fingertip bruising' and stated Personal Information was relaxed during the examination.

HV advised that she directed and emphasised to Mum to make sure that Personal Information was seen by the GP for assessment of the bruising on that afternoon - the Personal Information redacted by the USI at a pre-arranged immunisation clinic. This was recorded on the child's PCHR (Red Book) HV advised at interview that she told Mum that Personal Information would need his bloods checked. Mum agreed to see the GP with Personal Information and the HV had no doubt that Mum would attend the GP with Personal Information. HV advised Mum that she would follow up with GP.

HV confirmed during interview that during the visit with Mum and Personal Information she did not raise any child protection concerns with Mum or that she would need to immediately contact the GP and CPNS to discuss concerns about Personal Information's bruising. HV advised during interview following the incident that she had planned to contact the GP and CPNS that afternoon by telephone for advice and guidance but did not do this due to caseload pressures.

On the Personal Information redacted by the USI the HV completed her scheduled child protection home visits and returned to the office at around 11.40am.

The HV telephoned the CPNS on the Personal Information redacted by the USI but there was no reply. The HV's secretary advised that the CPNS was working in an area with poor mobile reception HV spoke to her Team Manager about the visit to Mum and Personal Information. HV returned a telephone call to Dr 1 in Acute Paediatric Ward who advised HV about the outcome of Personal Information's admission to hospital. The HV did confirm with Dr 1 that she advised Mum to attend the GP on the Personal Information redacted by the USI to have the bruising examined. She was advised that Personal Information was seen by three consultant Paediatricians HV agreed to complete a home visit on return from annual leave. Following contact with Dr 1 on the Personal Information redacted by the USI, the HV spoke directly to the CPNS to discuss the case and was advised to complete a follow up home visit on her return from annual leave. The CPNS did not advise the HV to submit a UNOCINI referral to Gateway There is no evidence in the child's record that the HV made contact with the GP however in the course of this enquiry it was confirmed that the HV had received further information from the hospital/

It was confirmed during interview that the HV had no previous contact with father. During interview HV confirmed following the home visit that on balance in light of the previous knowledge and assessment of the family she did not consider Personal Information's bruise's to be the result of NAI at that point in time but was waiting for further assessment by the GP. The HV's main concern at that time was that the bruising was possibly accidental due to the baby harness or secondary to a medical cause.

Analysis

In consideration of the information available it is evident that the HV fulfilled core health visiting responsibilities to a good standard up until the Personal Information redacted by the USI.

The health visitor's perception of the situation seems to have been that she thought the bruises seen on the baby's leg were unlikely to have resulted from physical abuse.
This was despite the facts that his Mum gave no clear explanation to account for the injuries seen and that she had only brought the health visitor's attention to the bruising when physical examination of the baby was imminent.

The appearance of a stable family environment, no overt signs of maternal distress and a contented baby overshadowed the significance of the unexplained bruising as a child protection concern.

The observable fact was the unexplained bruising. This indicated one of three possibilities;

- an underlying medical condition,
- unexplained accidental injury or
- non-accidental injury**.**

The course of action taken based on this diagnostic conclusion is understandable in that the health visitor advised Mum to show the bruises to the GP and trusted that Mum would do this.

The possibility of non-accidental injury was considered at the time of the visit as the health visitor sought to find plausible accidental mechanisms for the bruising. The significance of any unexplained bruising in a pre-mobile infant was not recognised.

Given these perspectives it appears that the health visitor did not see the need to discuss the case with the CPNS and/or completion a referral to social services and chose to await the outcome of further assessment by the GP before making a decision about making a referral to the Gateway Team.

Although the HV advised at interview that she did not disregard safeguarding responsibilities, there was a variation from what was expected within the regional and Trust policies and procedures and what was done i.e.

- Child protection concerns (unexplained bruises to a pre-mobile baby) were not raised with Mum during the visit on the Personal Information redacted by the USI
- The HV did not reprioritise work planned for the same afternoon to make time to contact the GP and CPNS to discuss concerns and agree actions required, including the requirement to make a UNOCINI referral to Gateway.

- The HV did not confirm directly with the child's GP regarding what they had observed, parental response and arrangements for the GP examination and follow-up discussion on outcome of the examination.

5.1.3 General Practitioner

The General Practitioner representative of the review team wrote to the family's GP for information. Subsequently there were two telephone conversations between himself and the family GP about the case. The family GP indicated that Mum presented for Baby [redacted]'s routine vaccination on [redacted]. She did not indicate to her GP any involvement with the Health Visitor earlier that day.

The GP made contact with Dr 4 in the local Paediatric Ambulatory Ward for advice. However, as a Consultant was not present Dr 4 advised the GP that they would need to speak to a senior paediatrician Dr 5 and having done so relayed back to GP that non accidental injury should be considered as a potential cause for consideration and that he should refer Baby [redacted] directly to the Acute Paediatric Ward. The GP completed a referral letter and under 'Reason for Referral and Urgency' stated:

"unexplained extensive old bruise, right thigh not distressed, please assess".

Under the section of 'urgency' it was marked as "routine". The review was advised that that 'routine' is a default setting and has no significance in this case.

The GP also rang the ward to arrange the admission of Baby [redacted]'s but did not recall who they spoke to.

Dr 4 in Ambulatory Paediatrics in Dungannon advises that she was contacted by the GP asking them to see a child with bruising to his thigh for X-Ray. Dr 4 advised that it was not appropriate as the child needed to be seen within the Acute setting to facilitate the range of investigations required The GP asked her again stating he had no concerns about this family. Dr 4 states she reiterated this was not the appropriate setting to see the child and offered to telephone Dr 5 for advice. Dr 5 advised that the child should go to the Acute Paediatric Ward for assessment and Dr 4 relayed this to the GP.

Analysis

On examination of the baby the GP was faced with the same differential diagnosis that had been confronted by the health visitor; an underlying medical condition, an unexplained accidental injury or non-accidental injury.

He perceived that the family had no significant risk factors in terms of child abuse and relayed this information to the hospital doctor from whom he sought advice. The GP's perception of the family was important and added weight to the on-going paradigm that this baby did not live in a home where abuse was likely.

The possibility of non-accidental injury was raised in discussions between the GP and the Dr 4.

In his onward referral the GP described the bruising seen as “unexplained, extensive and old”. Unexplained and extensive implies that abuse is being considered. However safeguarding concerns were not highlighted in the referral to the hospital and the referral was marked as routine. The review team did not establish that the GP expressed safeguarding concerns to the mother

The review team appreciated that an underlying medical cause for the bruising at this stage could not be ruled out and that the GP had acted appropriately to ensure the medical investigations were carried out and that Baby Persona l Informati was assessed and admitted to a place of safety. However, they believe that if the opportunity to contact the Gateway Service or Health Visiting to address any safeguarding concerns had been taken this could have impacted on subsequent conclusions as opposed to the matter being deferred to the next stage of the process.

5.1.4 Acute Nursing

Five paediatric nursing staff were involved with the care of Baby Persona l Informati from the period Personal Informati on [redacted]. Nurse 3 was in charge of the ward on the evening of Personal Informatio n redacted [redacted]. At 15.30hrs on Personal Information redacted by the USI [redacted] the CPNS was present in the Ward when a telephone call was received asking for baby Persona l Informati to be assessed due to unexplained bruising. At that time the CPNS recorded that she advised Nurse 3, Nurse 4 and Nurse 5 to complete a UNOCINI as unexplained bruising in a pre-mobile baby was suggestive of possible NAI. Nurse 4 and Nurse 5 do not recollect this.

On admission, Nurse 1 states she was asked by Nurse 4 to admit Baby Persona l Informati using the standardised Ward Attender Medical and Nursing Documentation. She understood the family had come to the ward with a referral from the GP. She states that she was not aware that there was a query of NAI of Baby Persona l Informat on admission and that this was not contained in the GP’s referral.

Nurse 1 observed the bruising. She states she “chatted” with Mum and dad during the admission process and asked them when they noticed the bruise. Mum stated she noticed it on Personal Information redacted by the USI and had brought Persona l Informati to the GP. Nurse 1 queried with them whether he could have hit his leg off something and Mum stated “no, nothing happened”. Nurse 1 felt they were appropriate and there was nothing in their demeanour to suggest otherwise. She states that she had discussions with staff after she completed the nursing sections of the ward attender documentation that the 3-4 bruises on his leg were significant when his leg was bent at the knee in that they formed a definite pattern. She did not document this observation on the ward attender sheet. On reflection during interview Nurse 1 expressed that if the parents had presented differently, i.e. unkempt,

smelling of cigarettes, she believes they may have been viewed differently and subsequently Baby Personal Information's bruises would have been reviewed in a different light. This was Nurse 1's only contact with Baby Personal Information.

Nurse 2 was asked by Doctor 2 to take bloods. Nurse 2 was not aware or informed of the content of the discussion which had taken place with the CPNS and nurses 3, 4 and nurse 5. During interview she described observing extensive bruising which was in her opinion an old bruise. She had been made aware before she took bloods that there was a query of non-accidental injury. The parents were cooperative throughout this procedure. Following this process, Nurse 2 discussed the case with Nurse 4 and Dr 2. She states she disagreed with Dr 2 when he claimed that the parents said it was due to a baby walker. Nurse 2 stated she told Dr 2 that the Baby was dependent and that she believed the explanation did not fit the injury (this is from second interview) Nurse 2 did not document this discussion. She recalls there was discussion regarding withholding the UNOCINI referral until the following day. Her understanding going off duty that evening was that Baby Personal Information was staying in the ward overnight and she was unaware what had occurred to change this plan. Nurse 2 learned of the outcome of the case on her return to duty on Personal Information redacted by the USI from colleagues. Nurse 2 stated she was surprised to learn of the outcome of the case – i.e. discharge with no follow up. However she did not express this view to anyone on that date.

Nurse 3 was present on the ward when Personal Information was admitted and is recorded as being present during the discussion which took place with the acute CPNS following the admission notification from Dr 5. She documented Personal Information's growth measurements and plotted the centile charts. She spent a short time with the family and described the parents as very pleasant and cooperative and Baby Personal Information as a normal, perfect baby. Personal Information volunteered to Nurse 3 that he was Personal Information redacted by the USI and mum was Personal Information redacted by the USI. On reflection at interview Nurse 3 reflected that these remarks regarding parental occupations were unprompted and unusual. She was aware that NAI was a query and knew that the health visitor and GP were also involved. When asked at interview why the policy and procedure relating to children with safeguarding concerns was not applied, i.e. UNOCINI not commenced she explained that the bruising was at that stage "unexplained" and they were keeping an open mind that night.

There was a discussion between Nurse 3, Nurse 4 and Dr 2 and Dr 3. There was a difference of opinion between the nurses as to whether the UNOCINI should be completed. However Dr 3 said they wished to hold on this action until the blood samples and further observations were complete. Nurse 3 then agreed with Nurse 4 that they would send notification emails to the CPNS and Hospital SW, and nurse 3 and 4 agreed as they knew Baby Personal Information would be staying the night the UNOCINI could wait.

Nurse 3 also mentioned that mum had stated she had been investigated for easy bruising. Nurse 3 was asked if she was alarmed at the bruising and she commented on the size of the bruise and that it was not something that would be missed. She recalls mum and dad trying to come up with the reasons for the bruising and that mum agreed with dad that he sometimes holds Baby Personal Information too tight. Nurse 3 recollected at interview

that it appeared mum and dad were genuinely trying to consider what could have been the cause of the bruising, however she also admitted no mechanism was determined. At this point in the evening Nurse 3's rationale for not completing the UNOCINI as requested to do so by the CPNS (that afternoon) was :-

- Blood results were still outstanding
- Further observation of parental interaction was required
- Baby Persona l Informati was in a place of safety

Nurse 3 recollects the blood test results coming back to the ward negative.

At approximately 9.15 pm Dr 2 asked Nurse 3 to talk with the parents as they were insisting they wanted to go home with Baby Persona l Informati that night. Nurse 3 described dad as being adamant that they wanted to go home and would return the next day. She states Dr 2 did try to impress on them that he was not happy for them to leave and he agreed to talk with Dr 3 about the situation.

Nurse 3 told the parents that if they left it would be contrary to medical advice but the parents stressed that they would come back as early as was required the following day but they did not want to stay. Nurse 3 recollected stating to parents that staff needed to follow policies and procedures but admits neither she nor Dr 2 discussed Child Protection issues with the parents or NAI.
Nurse 3 during interview reported that the possibility of signing a CTMA form was discussed with the parents and they were prepared to do so. Dr 2 did ask her if she was happy at that stage. Nurse 3 stated that she was satisfied and reported that her view was based on:

- The parents were so cooperative that she believed they would return to the ward.
- Baby Persona l Informati was so well and bright.
- She understood that the parents had a good relationship with their health visitor and their GP.

Nurse 3 also stated that if she had felt strongly about discharge, she would have told Dr 2 this. Nurse 3 recollected that when Dr 3 was contacted by Dr 2 he confirmed that the family could go home to return the following morning.

On reflection Nurse 3 acknowledged that she took the parents at face value and genuinely believed that they were very attentive, good parents but accepts this may have impacted on her objectivity,. Nurse 3 stated that she knew she should have phoned the Out Of Hours social work team but that the parents led the interaction and indicated they were very willing to return to the ward in a few hours.

Nurse 3 communicated with Nurse 4 and Nurse 5 on the night of Personal Information redacted by the USI while off duty in relation to Baby Persona l Informati going home and his return to the ward the following morning.

Nurse 4 is recorded as being present during the discussion which took place with the CPNS following the telephone conversation from Dr 4 regarding admission notification. But during interview Nurse 4 could not recall this discussion.

She was aware that Baby Persona l Informati was referred by his GP due to unexplained bruising. . Nurse 4 recalls that Dr 1 had a quick look at Baby Persona l Informati and asked the parents how the bruising had occurred. The parents felt it may have been the car seat. She recalls the parents' explanation as being a strange reason for bruising but did not record this in the notes. She recollected Dr 1 telling the parents that they had to establish how it had occurred and that blood tests would be carried out. Nurse 4 recalls that Dr 1 may have discussed NAI concerns with the parents. .

Nurse 4 completed the inpatient admission with the parents and asked them why they had come to the ward. She recalls they stated that they were worried about the bruise. Nurse 4 stated that she thought the bruising was in the shape of a hand. She stated she also asked the parents "how did it occur" and Mum said she noticed the bruising when changing Baby Persona l Informati nappy in the back of the car. Nurse 4 asked the parents who would be staying with Baby Persona l Informati on the ward and they questioned whether they had to stay. Nurse 4 completed the baby's measurements and these were documented by Nurse 3. Nurse 4 states that dad handled Baby Persona l Informati well. Following this, Nurse 4 updated Nurse 3 who agreed to do the Care Plan. Nurse 4 states that she placed baby Persona l Informati in a cot directly across from the nurses' station so that he could be closely observed by nursing staff due to the possibility of him having sustained a NAI.

At 18.30 hours the Hospital Social Worker rang and indicated that if there was any suspicion, Baby Persona l Informati should not go home. Nurse 4 relayed this to Nurse 3 and Dr 2 but did not document this. Nurse 4 described how she and Nurse 2 discussed their concerns with Dr 2 and said that the bruises were "finger marks - not a slap but grab". They also discussed the two versions of the accounts the parents had given for the possible cause this discussion was not recorded.

Dr 3 arrived on the ward to discuss the case with Dr 2. Nurse 4 states that Dr 3 said not to complete the UNOCINI until the blood results came back.

Nurse 4 went off duty that evening assured that baby Persona l Informati was to remain an inpatient and was in a place of safety. Nurse 4 updated baby Persona l Informati care plan to reflect he required "close observation on ward". Nurse 4 stated she was surprised to receive a lengthy text from Nurse 3 at 22.30 hours to say Baby Persona l Informat had gone home. Nurse 4 was back on duty on Personal Information redacted by the USI and spoke with the CPNS at lunchtime who instructed her to complete a UNOCINI. The CPNS "Record of safeguarding children staff contact with CPNS" details that Nurse 4 agreed to complete UNOCINI. Nurse 4 stated she was concerned about completing a UNOCINI as:-

1. She did not have parental consent
2. The Consultants had said baby Persona l Informati bruising was not NAI.

The CPNS advised Nurse 4 to start a UNOCINI and she would then visit the ward to offer advice in relation to its completion.

Nurse 4 stated at interview that on Personal Information redacted by the USI she updated the Ward Manager in relation to the situation and there was a subsequent discussion between herself, the Ward Manager and the Head of Service in relation to completing the UNOCINI. The review team has established that prior to this discussion the Head of service was contacted by the Assistant Director of Specialist Child Health & Disability who had made the decision that a UNOCINI should be completed on the grounds of child protection. Nurse 4 felt uncomfortable about phoning Baby Persona l Informat parents for consent in relation to the UNOCINI and therefore it was agreed that that the Ward Manager would phone the parents. Nurse 4 then described how subsequently the Head of Service contacted the Ward to advise that consent was not required and therefore the parents did not need to be phoned.

Nurse 4 states that the Head of Service then re-contacted the Ward Manager and stated that following discussion with the Assistant Director of Family Support & Safeguarding that a UNOCINI did not need to be completed by ward staff. (SEE 5.1.8 p. 47)

Nurse 5 was made aware of Baby Persona l Informat's admission late in the evening on Personal Information redacted by the USI while she was off duty by a telephone call from Nurse 3. She understood that he would be back on the ward the following day and that Nurse 3 had given the parents Nurse 5's name as a contact point in the morning. She understood they were asked to present on the ward at 10.30.

Nurse 5 recalls that the morning of Personal Information redacted by the USI was very busy on the ward with a number of admissions and an antibiotic audit that she had to complete. Nurse 5 stated that she had not had an opportunity to read in full baby Persona l Informat notes to familiarise herself with his care.

Nurse 5 recalls that at approximately 9.30 am that the hospital social worker was reading the Baby's chart and was surprised that he had gone home the previous night. Dr 3 also asked where Baby Persona l Informat was and stated that if they did not arrive, they must alert Social Services.

Nurse 5 recollects ringing both the CPNS and HV seeking advice and background but received no answer and left messages for both to return her call.

Nurse 5 rang the family twice managing to speak with them at 11.20am and they confirmed they were on their way arriving on the ward at 11.40am. Nurse 5 accompanied Drs 1 and Dr 3 into the treatment room. She recalls Dr 3 asking the parents how the bruises had occurred and she described how the parents were really trying to come up with a reason She felt they were plausible and she did not express concern about this. . Nurse 5 conveyed that prior to the examination, non-accidental

injury was being considered by professionals as a possible cause for the bruising to baby Persona l Informati thigh.

Following the examination, Dr 1 and Dr 3 left the treatment room and had a discussion with the Hospital Social Worker. Nurse 5 stated that on reflection she should have taken part in this case discussion but she was called to a phone call from someone who had previously been trying to reach her that morning. Nurse 5 therefore missed the case discussion – she reflected at interview that in hindsight she should have postponed the call and taken part in the discussion.

The CPNS returned Nurse 5's earlier phone call at 3.30pm and on hearing that Baby Persona l Informati had been discharged, instructed Nurse 5 to complete a UNOCINI. Nurse 5 stated that she felt that she was not the best placed person to do this as she had had limited contact with the family and suggested the CPNS should ask Nurse 3 who was coming onto night duty to undertake this. She did not give consideration to the delay this would cause. Nurse 5 stated at interview that had the CPNS contacted her first thing on that morning she would have been more focused on completing the UNOCINI and on the case in general. Following this discussion with the CPNS Nurse 5 did not consider telling the Dr 1 and Dr 3 that the CPNS was not happy about the decision to discharge Baby Persona l Informati to the community nor did her documents this in the records.
The admission assessment and discharge policy was not initiated or completed by the staff involved in this case.

At second interview Nurse 3 commented that on occasions there had been disparity within the nursing workforce in relation to role of the CPNS. Nurse 3 advised that the ward manager had in the past been negative about nursing staff contacting the CPNS for advice, however this had recently changed.

As is evident from above review team agreed to interview Acute nursing staff involved in this case a second time to clarify why the advice from the CPNS was not followed and if there were any specific concerns in relation to implementing Regional and Trust Child Protection policy and procedures.

The following themes arose from these interviews:

- Four out of five of Acute Nursing staff involved reflected the perception that the CPNS role should be one that should have a greater ward presence, should be involved in a "hands on" role in respect of Child protection decisions, should provide physical support in relation to having difficult conversations with parents in relation to child protection and in the completion of UNOCINI referrals. This perception was strongly reflected and it appeared to the review team that this may have an adverse effect on acute ward staff completely embracing their roles and responsibilities in relation to child protection issues. This perception was despite the CPNS being on the ward and advising staff to complete a UNOCINI.

- Four out of five nursing staff do not believe that they are adequately equipped to undertake the difficult discussions with parents that arise out of potential NAI and child protection cases. A significant part of their role is caring for medically unwell children in complete collaboration with their parents and the child protection area requires them to function in a different role - being an advocate solely for the child

- There was lack of clarity and understanding in relation to the UNOCINI referral despite bespoke training provided in October 2012.

- There was a variable response to the need to challenge decisions taken within the context of a clinical team – some feeling able to challenge while others did not.

Analysis

Emerging themes from analysis of information given during the interviews with the five nurses and following review of the documentation are as follows:-

Responding to Professional Advice

- There was evidence of discussion between the CPNS and nursing staff on four separate occasions over a three day period ([redacted]). On each occasion the CPNS advised nursing staff to complete a UNOCINI. This advice was not followed for a number of reasons:

    - On [redacted] nurse 4 did not complete the UNOCINI, as Drs 2 and 3 had advised a UNOCINI unnecessary at that time as blood results were outstanding.
    - On [redacted] Nurse 5 reported that she did not feel she was the right person to complete a UNOCINI and wished to wait until nurse 3 came on duty to complete it, as that nurse had been more involved in baby [redacted] care.
    - on [redacted] nurse 3 did not feel a UNOCINI was required as there were no concerns

In conclusion the advice and recommendations of the CPNS which were reflecting regional and Trust policies and procedures was not taken up by the Nursing team, reasons for not accepting the CPNS view were verbal and not documented. Nursing staff did not record the content of their discussions with the CPNS and did not reflect this difference of opinion in potential management to the other members of the clinical team, including the Consultant staff. The review team considered that nursing staff were given clear direction by the CPNS and noted that she was willing to return to the ward on the [redacted] to assist with the completion of the UNOCINI.

Policy and Procedure/Documentation

- The SHSCT "Admission, Assessment and Discharge Policy and Procedures for Children and Young People about whom there are Safeguarding Concerns" and SHSCT "Policy, Procedures and Guidance for Registered Nurses, Midwives and Specialist Community Public health Nurses on Safeguarding Children and Young People" were not adhered to. All nursing staff interviewed stated that they were familiar with both policies and that they were available at ward level.

  In particular:

Admission, Assessment and Discharge Policy and Procedures for Children and Young People about whom there are Safeguarding Concerns

1. The section headed "Procedures" specifically the last point 1.1 (Admission) states *"when the deliberate harm of a child or young person has been raised as an alternative diagnosis to a purely medical one, the diagnoses of deliberate harm must not be rejected without full discussion with the multi-disciplinary team and if necessary obtaining a further medical opinion".* There was no evidence of any multidisciplinary discussion in this case. The CPNS documented discussion of the case with nursing staff, nursing staff reported discussing safeguarding concerns with medical staff, nursing staff reported witnessing medical staff discussing the case with social work staff but the opportunity was never afforded for multi-professional discussion and the variance in opinion on the way forward was therefore not debated. It is the review team's opinion that the opportunity to debate the case may have resulted in a different care plan for Baby Persona l Informat as issues such as the background and appearance of the parents could have been examined in an objective and dispassionate way. The facts of the case – negative blood results , no clear mechanism of injury, the requirement to focus on the safety of the child and implement policies and procedures, no matter how difficult, may have been agreed and led to a different outcome.

Documentation/Record Keeping

- The "Pathway when child protection procedures are required" (a checklist) contained within the ward multi-professional care pathway was not commenced. There was nothing noted in this pathway in relation to baby Persona l Informati admission on Personal Informatio n redacted Personal Information redacted by the USI . Nurse 4 who was responsible for the completion of the admission documentation and recognised when interviewed that it was incomplete.

- Nursing notes/evaluations failed to reflect all the observations and discussions with the parents and staff which took place regarding this case. In addition they were not contemporaneous– a number of retrospective notes were evident.

- The nursing staff recalled the extent of the bruising on baby [redacted] right outer thigh, however body maps were not used by any member of nursing staff to record this bruising as per the Southern Trust policy.

- During interviews a number of the nursing staff recounted discussions they had with medical staff about baby [redacted] suffering a NAI. These discussions were not subsequently documented in the nursing evaluation.

- During interviews between nursing staff and parents there were different explanations given for the cause of the injury, (baby walker, car seat, father holding baby tightly) and when the parents noted the bruising (changing baby in car and whilst bathing [redacted]) these discussions were not fully documented.

- There is little evidence within the nursing care plan and evaluation that nursing staff had given consideration to baby [redacted] being subject to NAI. There is only one section of the nursing evaluation that is specific to safeguarding, documenting a discussion of this nature with baby [redacted] parents. This pertains to the evening of [redacted] when baby [redacted] parents were insistent on taking him home overnight. On [redacted] Nurse 3 made a retrospective note documenting that she spoke to the parents about the need for staff to adhere to policies and procedures in relation to safeguarding. The child specific care plan notes:-

  1. "Liaise with social worker/H Visitor. If any concerns liaise with CPNS"
  2. "Observe parents interactions with [redacted]"

- Three separate nurses were involved in admitting and assessing baby [redacted] on [redacted]. Nurse One completed the nursing section of the "ward attender medical and nursing documentation". Nurse 3 and 4 completed the full nursing admission documentation and care plan. It was unclear from the records who the named nurse was for baby [redacted] and who was taking responsibility for leading on baby [redacted] care.

Training

- All five nurses were able to recount significant safeguarding training given to them, especially in the weeks and months prior to baby [redacted] admission. The most recent and junior member of nursing staff interviewed was able to discuss that safeguarding training formed part of her induction programme. All of the nurses interviewed felt equipped to complete a UNOCINI. However from the second interviews with the majority of nursing staff it was evident that whilst the theoretical component of the recent safeguarding training had been attended there was a deficit with regards to nursing staff transferring theory into practice. The majority of nursing staff were unable to articulate what process a UNOCINI triggered and the different types.

Nursing staff discussed that because baby [redacted] parents presented themselves as articulate, well dressed and well mannered, an assumption was made that they could not have caused a non-accidental injury to their son. Baby [redacted] was also presented as a happy, well fed and well-dressed baby who interacted with his parents and the nursing staff caring for him.

Nursing staff did not challenge the decision made to discharge baby [redacted] to home in the care of his parents on the evening of [redacted], despite being aware that no organic cause for the unexplained bruising had been found. The majority of nursing staff verbalised that they were uncomfortable having difficult discussions with parents in relation to safeguarding and were unsure of the correct form of words that could be used. Some nursing staff reported that they would be comfortable challenging medical staff were there to be dissenting views. One Nurse commented that she would not feel comfortable challenging senior medical staff. Some nursing staff verbalised that some of the medical staff would be easier to challenge than others.

5.1.5 THE ROLE OF ACUTE CONSULTANT PAEDIATRICIANS

This section is laid out under the following headings:

1. Acute Paediatric Attendance and Admission on [redacted]
2. Acute Paediatric Attendance [redacted]
3. Subsequent Actions within Acute Paediatrics
4. Acute Paediatric Admission [redacted] (brief description)

1. Acute Paediatric Attendance and Admission on [redacted]

Baby [redacted] was admitted to the Children's Ward in Craigavon Area Hospital at 1710hrs on [redacted]. He was [redacted] old.

The first medical notes were written by Dr 2 at 1800hrs.

Dr 2 is employed as a Consultant Paediatrician in the Trust but at this time was working on the middle grade rota.

Dr 2 recorded taking the history from both parents in the presence of Nurse 3 in the ward.

He wrote that that the baby had been referred by the GP for bruising on the right thigh and leg. He documented that the baby's Mum had first noticed the bruise on the right thigh and leg 2 days previously when she changed his nappy after coming from a walk with the baby.

The bruise was reported to have "got darker" on the day prior to this admission. Dr 2 wrote that "because she has an appointment for immunisation today she decided to ask

her GP about the bruise today who referred her to the hospital. Dr 2 proceeded to record the birth, immunisation, drug history and past medical history.

He recorded in the family and social history that Baby Personal Information redacted by the USI was an only child, that his Mum was Personal Information redacted by the USI and his father Personal Information redacted by the USI. He also recorded that the baby's main carer was his Mum and that there was a maternal history of "easy bruising".

Dr 2 carried out and recorded a medical examination which detailed on small body maps the bruising seen on the right leg.

Dr 2 recorded that;

> **1**. There are two linear bruises extending from anterior surface of right thigh towards the posterior aspects going together then. Green in colour each measuring 6x1cm.
> **2.** On right lower leg there is a bruise of same colour as the above extending from horizontally from the anterior posteriorly measuring 4cm diameter….1cm".

In his summary Dr 2 stated that this was a Personal Information redacted by the USI old boy with unexplained bruises to right thigh and right lower leg. He stated that both parents were "appropriately behaved".

Blood investigations were arranged and a full blood picture, coagulation studies and C-reactive protein were sent.

The plan was to observe overnight, discuss with Dr 3 (Consultant on call) and advise Hospital Social Worker to assess the following day.

Analysis

There is clear inference in the medical notes that child protection concerns were being considered at this stage. Dr 2 gathered his history with a senior member of the nursing staff as a witness, recorded the bruising as unexplained and intended to speak to the social worker the following day.

Dr 2 was aware that the baby's GP had sent him to the hospital for investigation of unexplained bruising but was of the understanding that his Mum had taken the opportunity of routine immunisation to show the GP the bruises. This misunderstanding of the presenting events may have given the impression that the baby's Mum facilitated the investigation of the bruising on her son's leg.

Considering child protection concerns were evident there were few details recorded in the medical notes about the events before the bruise was noted. There was no recording of enquiry of mechanism and little detail concerning the events surrounding "the walk" after which the bruising was first reported to have been seen.

The relevance (or irrelevance) of maternal "easy bruising" was not explained or expanded in the medical notes and the bearing of this on Dr 2's medical investigation or subsequent differential diagnosis was not apparent.
No differential diagnosis for the unexplained bruising was recorded.

It became evident in the subsequent investigation of this case that Dr 2 had taken pictures of the baby's bruises on his mobile phone. This was clarified during interview and Dr 2 stated that he obtained verbal consent from both parents to do this. The medical notes do not record that photographs were taken and there is no record of verbal consent being given. There is no record of the conversation that Dr 2 had with the parents in relation to photography and the recording and storage of this information.

At interview Dr 2 stated that verbal consent from the parents for photographs "was enough". He took the photographs as an 'aide memoire' for writing up his notes outside the assessment room.

This course of action, in relation to photography in cases where abuse is suspected, is outside of regional guidance (1) when child abuse is suspected (Section 8.17).

During the interview Dr 2 reported the nursing staff told him that the baby's Mum was Personal Information redacted by the USI. He said that he was not influenced by this. It was his impression at the time that the bruising was unexplained and that the baby was non-mobile but "the parents were appropriately behaved". Dr 2 stated that he hoped the blood tests would explain things.

Dr 2's next entry in the notes was made at 2100hrs.
At this time the baby's father is reported to have provided an explanation for the bruising; that he was holding his thighs when going downstairs in the Personal Information redacted by the USI and that this was the only explanation that he (father) could see.

Dr 2 did not record his opinion of this explanation.

Both parents were very determined that they did not want to stay in the hospital that night and Dr 2 contacted Dr 3 who advised him that they could go home to return the following day for further assessment.

The blood results showing no evidence of a coagulation problem were recorded in the notes at 0015hrs (Personal Information redacted by the USI). At interview Dr 2 stated that the blood results were known prior to him contacting Dr 3 and the plan to discharge with return the following morning.

At interview Dr 2 stated that the baby's Mum said that she would sign CTMA form to leave the hospital against medical advice. He recalled that the parents were adamant about going home and that there was "high temper". Dr 2 said that he was surprised at the parental response and had "got one of the nurses to talk to them". He stated at interview that it was his opinion that the child needed to stay as he was a child with unexplained bruises and he had to follow "our guidelines".

Dr 2 stated that he phoned Dr 3 and told him that he did not know what to do. He recalls Dr 3 telling him to let them (the family) go home and that he (Dr 3) would see them in the morning.

Dr 2 at interview stated that Dr 3 has a wide range of child protection experience and that he "had to follow his direction and instructions".

He also thought that he did not think the parents had harmed the child, stating that, "It is very rare to find two parents together. You expect one of them to report the other."

He restated at interview that Dr 3 was more experienced than he was and that if he had had to make the decision on his own in relation to child protection concerns he would have escalated concerns that night.

It was clear during the initial interview with Dr 2 that he thought this case was difficult to handle and he thought the Child Protection Lead (Dr 3) should take the lead. Dr 2 stated that, "this is not a middle grade job….the Consultant should have come in and dealt with them". He also stated that he expected his senior to make the right decision.

Dr 2 was of the opinion that middle grades should not deal with child protection and that this is a Consultant role.

When asked about the relevance of skeletal survey in this case Dr 2 stated that, "to be honest, most of the time they come back normal".

At initial interview Dr 2 was of the opinion that "this was a very rare case".

Further clarification was sought through a second interview with Dr 2 as part of the review process. Dr 2 recounted how he had no hesitation that the parents would come back to the hospital with the baby and that he respected the opinion of Dr 3 in this case as he was the senior doctor and the child protection lead. Dr 2 stated that he would have challenged Dr 3's decision if he had disagreed with him. He reiterated that decisions in child protection matters should be made by the Consultant Paediatrician and not the middle grade doctor.

Analysis

On the night of Baby [redacted]'s admission to the hospital Dr 2 was working on the middle grade rota. He is employed as a Consultant Paediatrician in the Southern Trust In this case Dr 2 deferred decision making in relation to child protection matters to the Consultant on call who was also the Designated Doctor for Child Protection in the Southern Trust. Dr 2 did not take responsibility for decision making that night in relation to Baby [redacted]. Dr 2 further stated that it is his opinion middle grade doctors should not be involved in child protection.

The ACPC Regional Guidelines (section 8.15) [1] give specific guidance for medical practitioners on the medical assessment of alleged or suspected physical abuse. These are guidelines for all doctors. Child protection is everyone's business and Dr 2 should have been aware of the procedures required when investigating a case of suspected physical abuse.

Dr 2 is employed as a consultant paediatrician and also participates on the middle grade rota. Dr 2 believes that on the evening of Personal Information redacted by the USI he was on duty as a Middle Grade, however the Trust would be of the opinion that he is employed as a consultant paediatrician.

Dr 2's actions and recordings confirm that he did consider that Baby Persona l Informat's bruises were unexplained and that he was considering non-accidental injury as a possible cause. Dr 2 may have been swayed by his perception of the baby's parents and his opinion that their behaviour was appropriate.

Dr 2 deferred a difficult conversation when the parents were insistent on leaving the ward to the nursing staff. He did not recognise that the parental behaviour itself was a 'red flag' from a safeguarding perspective.

At the time of this baby's discharge from the ward the bruises to his leg were unexplained and blood results were known to be normal. Child safeguarding procedures to keep this baby in hospital should have been put into place. Dr 2 failed to understand his role in the appropriate investigation and protection of a pre mobile infant presenting with unexplained injuries as defined in Regional Child Protection Policy and Procedures. The Admission, Assessment and Discharge Policy and Procedures for Children and Young People about whom there are Safeguarding Concerns (Southern HSCT June 2011) [2] reflect regional and national guidelines as to the assessment, discharge and recording in cases of suspected abuse.

Dr 2 did not follow these procedures.

Involvement of other Medical Staff at the time of Ward Admission/Discharge on Personal Information redacted by the USI

While the medical notes recorded the actions of Dr 2 at the time of Baby Persona l Informati's admission and discharge on the Personal Information redacted by the USI it was apparent through the notes and during the interviews that other doctors were involved at this time.

Dr 1

Dr 1 was the Consultant Paediatrician in charge of the paediatric ward for the week beginning 26-11-12.

He was aware of the baby's admission to the ward before he left at 1700hrs.

Dr 1 was aware the baby had been referred by the GP because of unexplained bruising but he was unaware of the exact mode of referral.

He chose to quickly see the child before he left the ward. He remembered (at the time of the interview) that Baby Persona l Informati was extremely content when he examined him on the ward. He stated that the bruising on his right leg was "purple and had a linear quality". He recalled that at the time he thought that the bruising could be indicative of child protection issues.

Dr 1 examined the baby's abdomen to check for any liver or splenic enlargement which can be associated with conditions such as leukaemia. Organomegaly was not apparent at examination.

Dr 1's opinion was that this was a thriving, well looking baby with unexplained bruising who needed further blood investigations and full assessment. He was concerned that it may be a medical condition such as idiopathic thrombocytopenia purpura and remembered telling Dr 2 that if the platelets were normal child protection concerns should be considered.

Dr 1 had no further involvement on the Personal Information redacted by the USI.

Analysis

Dr 1 had seen and examined Baby Persona l Informati on the evening of his admission.

Dr 1 should have documented contemporaneously his involvement including any history he took, the findings of physical examination and advice given to Dr 2 that in absence of medical explanation safeguarding concerns should be considered. This is in contravention of local and regional guidance.

Dr 3

Dr 3 was the Consultant on call on the night of the Personal Information redacted by the USI. His role in the hospital at this time was Consultant Paediatrician and Designated Doctor for Child Protection.
Dr 3 did not document his involvement on the Personal Information redacted by the USI in the medical notes. Clarification was sought at the time of interview.

Dr 3 explained that he was on call on Personal Information redacted by the USI.

He reported that he had heard that a local GP had phoned in relation to a baby with a bruise. He had called into the ward around 1700hrs but the baby was not there yet.

At around 8pm Dr 3 called into the ward again. He was en route to the airport (to collect a family member) and had arranged Consultant cover for this time period with Dr 6.

When on the ward at this time Dr 2 showed him pictures on his mobile phone of bruising on the leg of baby Persona l Informati

Dr 3 recalled that the report given to him by Dr 2 was that the bruising had been picked up incidentally by the GP during a routine visit (for immunisation) and that Dr 2 had told him that the GP had "no concerns about the parents".

Dr 2 is reported to have told Dr 3 that the bruising occurred while the parents were walking around the Personal Information redacted by the USI and may have gripped the child around the leg.

Dr 3 did not see Baby Personal Informatio n at this time.

Dr 3 left the hospital and handed over to Dr 6 for a short period (on call from home).
Dr 3 did not report reading Dr 2's clinical notes at this time.

Dr 3 did not document his discussion with Dr 2 in the medical notes.

On return to on call duty later that night Dr 3 recalled being phoned twice by Dr 2. The first call was about a child on the ward who had haematemesis.
The second was a call from Dr 2 to tell him that, "Baby Persona l Informat's parents were going home, not wanting but going". Dr 3 was of the understanding that the parents were adamant about going home.

When asked at interview if he and Dr 2 were considering child protection issues at this time Dr 3 stated, "Yes, all the time".

Dr 3 said that Dr 2 had asked the parents to stay and that they insisted on going home.

Dr 3 stated at interview that it was his opinion that, "We can't stop them".

The arrangement with the parents was that they would return the next day at 10:30 am for further assessment of the baby's bruises.

When asked if an Emergency Protection Order was considered, Dr 3 said that he thought that it may not come through before 10:30am the following day.

Dr 3 was keen to "get the co-operation" of parents and that a principle of the Children's Order was to try and "keep the parents onside".

Dr 3 was aware that the blood tests were normal at this time. He stated that the parents' explanation may have been plausible and that a bigger picture could be obtained the following day.

Dr 3 was asked at interview if the parents reported professional status coloured his opinion and replied, "Yes, probably".

Analysis

Dr 3 visited the ward prior to handing over to another doctor for a short period. While he was there, Dr 2 showed him photographs of the Personal Information redacted by the USI old with bruising on his leg that he had taken on his personal mobile phone and discussed the explanation for this as detailed above.

Dr 3 did not take this opportunity to examine the child. He did not document his discussion with Dr 2 nor his opinion as Designated Child Protection Doctor as to the nature of the injury seen. He did not challenge the consent and confidentiality issues in relation to the inappropriate photography of this child's injuries onto a personal mobile phone.

Factors that influenced this clinical decision on the evening of Personal Information redacted by the USI included;

- Dr 3's interpretation of the photograph taken of the baby's injuries,
- The history given by Dr 2,
- The phone call indicating the parent's insistence on discharge from hospital,
- The perception of the parents being a professional couple
- And the understanding of the Children's Order as recommending keeping the parents 'onside' rather than the paramountcy of the child when abuse is suspected.

The Children Order (NI) 1995 (Section 65) (3) sets out legislation in relation to the removal and accommodation of children in emergency situations. This framework was not followed for Baby Persona l Informati on Personal Information redacted by the USI.

The review team concluded that Dr 3 did not comply with local SHSCT and the Regional Child Protection Policies and Procedures on the assessment and discharge of children with suspected non-accidental injuries.

2. Acute Paediatric Attendance Personal Information redacted by the USI

Baby Persona l Informati on was seen on the Children's Ward on the morning of Personal Information redacted by the USI. The appointment had been made for 1030hrs. Baby Persona l Informati on had not been brought to the ward at 1100hrs when Dr 1 completed his ward round.

Dr 1

Dr 1 returned to duty on the morning of Personal Information redacted by the USI. He found out at the time of handover that Baby Persona l Informati on had been discharged from the ward and he thought this unusual (reported

at interview). He contacted Paediatric Radiology at 0930hrs to verbally request in advance a skeletal survey and a CT scan as he was of the opinion that these would need carried out when the baby was reassessed later that morning.

When the baby was not on the ward at the arranged time Dr 1 with others (nursing staff) became concerned. Dr 1 stated that the nursing staff were surprised that the baby had been discharged the previous night and he regarded this as "an exceptional decision".

There was anxiety about the decision made particularly as the child did not appear on the ward at the arranged time.

Dr 1 at interview recounted how Dr 3 arrived in the ward during this period of heightened anxiety. The social worker was involved and there was a discussion in relation to the need for an Emergency Protection Order. The parents were contacted by phone and reported that they were close to hospital and they had thought they were meant to be there at a different time. Baby Personal Information and his parents arrived around 1130hrs.

Dr 1 joined Dr 3 in the same room while he carried out a physical examination of the baby.

Dr 1 took the history from the parents in relation to how the bruising happened and the baby's general health.

Dr 1 did not carry out the physical examination. He observed Dr 3 carry out the physical examination and (at the time of initial interview) gestured how Dr 3 had cupped his hand close to and around (but not touching) the baby's right leg.

Dr 1 asked the baby's father about the walk at the Personal Information redacted by the USI. He remembers the father reporting that he was holding the baby around his chest/trunk during this walk. The baby's father indicated that he had not held the child around his legs.

Dr 1 asked about the hip examination that had been arranged for asymmetrical leg creases noted on previous examination of the baby but this appointment had not as yet happened and the baby had not had this type of physical examination.

Dr 1 tried to establish a cause for the injury but no causal mechanism was apparent. After this examination Dr 3 is reported to have asked Dr 1 to step out of the examination room with him. Dr 3 is reported to have said that he could not call this non-accidental injury as the threshold had not been reached and there was no pattern of injury.

Dr 1 asked (or commented) about carrying out "a skeletal survey or anything". Dr 3 did not think these were needed and stated that the child could go home, that the injury was accidental and that no follow up was required.

Dr 1 reported following the lead of Dr 3.

At the time Dr 1 did not challenge the decision made by Dr 3.

The baby was recorded as leaving the ward with his parents at 12.15hrs.

Dr 1 did not record the history taken from the parents nor his discussion with Dr 3 in the medical notes at this time.

Dr 1 subsequently recorded these events on Personal Information redacted by the USI.

A second interview was carried out with Dr 1 to seek further clarification of events around the time that this clinical decision was made. Dr 1 was clear that he respected the decision made by Dr 3 because he was the expert on child protection issues. Dr 3 was reported to have come to his decision quickly and that he (Dr 1) trusted his opinion.

Dr 1 did not recall Dr 3 asking him his opinion. Dr 1 did not feel pressurised to go along with this decision.

Dr 1 was returning to the ward expecting to see Baby Personal Information as an inpatient that morning. He anticipated that a skeletal survey and a CT scan of brain would be required later that day as per protocol when dealing with cases of unexplained bruising in pre mobile infants. He became worried when the baby was not returned to the ward at the expected time and was aware that this anxiety was shared with other professionals on the ward.

During the assessment and examination of this child by Dr 3, Dr 1 perceived his role as a support to Dr 3.

Dr 1 had child protection concerns but deferred decision making to a colleague who he regarded as having more experience and authority in child protection matters.
Throughout his interview Dr 1 indicated that this was common practice with the medical staff involved with Baby Personal Information.

Once the decision was made that the bruising was accidental, the radiological examinations planned were cancelled and the baby was allowed home.

Dr 1 was not convinced that he had heard any plausible explanation for the injuries on the baby's leg. There was no evidence of any differences of medical opinion between Dr 1 and Dr 3 throughout the medical notes or during subsequent interviews.

Dr 1's opinion was that the decisions around thresholds in relation to child protection concerns were made by the Designated Child Protection Doctor (Dr 3) and that in this case he was not of the opinion that the threshold had been met to carry out further medical investigations or escalate child protection procedures. Dr 1 was accepting of Dr 3's opinion.

It was evident, particularly in the second interview carried out with Dr 1, that there were, from his perspective, professional differences within the multidisciplinary team in relation to determining the clinical thresholds diagnosing non accidental injury and therefore triggering a referral to social services for a child protection investigation.

Dr 1 stated that in practice doctors are asked to make the decision around recognising child abuse and therefore they are the ones that determine the threshold for referral to social services for a child protection investigation. Dr 3 is reported to have been of the opinion that a UNOCINI referral should not be triggered unless a clinical threshold for suspecting abuse has been reached.

Dr 1 described an unresolved issue in respect of the role of the child protection nurse specialist in relation to her involvement 'at the coalface' of child protection cases in the paediatric ward. These concerns were reported to have been expressed to senior management.

Dr 1 discussed during interview that in his view, there were historical difficulties in the senior management team in the Southern Trust in relation to the management of paediatric issues including concerns about child protection. He reported unhealthy relationships between members of the senior management team and medical staff leading to discontent among senior clinicians including Dr 3.

Dr 1 postulated that these issues formed the context and background as to how medical decisions were made in cases where there were child safeguarding concerns.

Analysis

While child protection is supposed to be everyone's business it was evident that in this case a uni-professional determination was made that the injury was not a non-accidental injury therefore the threshold had not been met to trigger child protection procedures.

Following the death of Victoria Climbe the Laming Inquiry [4] recognised the risks of uni-professional decision making in child protection cases.

The diagnosis of non-accidental injury was excluded in this case without multi-disciplinary discussion. Local policies and procedures recommend that full discussion must take place with the multidisciplinary team.

The review team are of the opinion that multi-disciplinary discussions would have alerted safeguarding concerns, as this would have raised awareness of the process of the pathway of referral from HV to GP to Hospital, the number of explanations for the cause of injury, the different explanations when bruising first noticed by parents and no medical explanation found for the cause of the bruising to Personal Information.

When the deliberate harm of a child has been raised as an alternative diagnosis to a purely medical one, the diagnosis of deliberate harm must not be rejected without full discussion and, if necessary, obtaining a further opinion.

Local policies and procedures (2) recommend that this full discussion should take place with the multidisciplinary team.

While Dr 1 agreed to the decision made by Dr 3 no detailed discussion or exchange of views took place and the opinions of the multidisciplinary team were not considered before the baby was discharged from hospital.

Dr 3

Dr 3 saw the hospital social worker on the morning of the Personal Information redacted by the USI and a check had been carried out with social services to see if there had been any previous involvement with Baby Personal Information and/or his family. No previous contact was recorded.

On the baby's arrival to the ward with his parents Dr 3 carried out an examination and recorded his findings in the medical notes.

On examination Dr 3 recorded that; there was a bruise "old 2 cms below the right knee and one above the right knee. No pattern seen. No other bruises noted. Mouth normal. Child very happy. Parents appropriate".

Dr 3 recorded discussing with social services and Dr 1.

Dr 3 was happy to let parents home. At interview Dr 3 stated that he did not (at the time) think that the bruising, with the information that was available, met the threshold for non-accidental injury. He remembered advising the parents about careful handling.

During the interview Dr 3 stated that he had considered a skeletal survey but was concerned about the dose of radiation and did not think the indicators were there to warrant this investigation.

In Dr 3's opinion a diagnosis of non-accidental injury could not be justified at this time.
Dr 3 stated at interview that in terms of child protection decisions, "sometimes you get it right, sometimes wrong…possibly this time wrong".

In retrospect he thought he was "coloured by the parents presentation", thought they had "pulled the wool over his eyes" and that the "Personal Information redacted by the USI were cleverer at covering up".

At the time of his assessment of Baby Personal Information he thought the parents showed appropriate concern and that he did not "have enough" to warrant further investigation.

He did not consider joint assessment with the Forensic Medical Officer nor asking for police photography as these could only be accessed if the decision is to proceed with child protection investigations.

Dr 3 also had concerns about complaints from parents made when doctors raise child protection concerns.

Analysis

Dr 3 documented a brief note in the medical chart which referenced the admission the previous night from the GP 'some bruises' on the right leg.

The Regional Child Protection Policy and Procedures(1) sets out specific standards for history, examination and investigation when medical assessment is carried out for alleged or suspected physical abuse (Section 8.15).

Doctors should:

- Record the person(s) present at the assessment and his (their) relationship to the child. Record those with parental responsibility and from whom consent was obtained. Record date, time and venue.
- Record a full paediatric history, including explanations of the abuse the carer and/or other relevant person(s) present. Document when abuse was reported to have occurred. Record both times and details.
- The general history should include (where possible) antenatal, neonatal, developmental, social and family history.
- Record parent's/carers expressed concerns about the child e.g. behaviour, health and development.
- Document the previous medical history.

Dr 3 did not document a detailed history and in particular, there was no recording of how these injuries occurred in his notes.

In terms of physical examination the above Policies and Procedures states that doctors should:

- Consider in detail the whole child; the full examination should include measurement of growth parameters with the use of centile charts, assess nutritional status, general appearance, level of hygiene, signs of neglect and development. The interaction of the child with the parent, carer and examining doctor(s) should be commented on.
- Diagnosis of physical abuse involves the assessment of lesions visible to the unaided eye. Accurate documentation should be achieved by means of words, drawings with measurements and photographs supplemented where appropriate by x-rays.
- A full skeletal survey is recommended in children under the age of 2 years, with a follow up chest x-ray 2 weeks later.

Dr 3 did not comply with procedures for the medical examination of suspected physical abuse as he did not record the above details in the medical notes and the skeletal survey was cancelled following this assessment.

It is also recommended that:

- The outcome of assessment should be clearly verbally communicated immediately by the examining doctor(s) to social services (where appropriate) and the police (if involved). This should be followed by a written report as soon as practicable.
- The child's GP, health visitor and any other relevant health professional should be notified of the examination.
- The examining doctor(s) should make arrangements for treatment and follow up of health care of the child as necessary.

Dr 3 did document that he discussed the case with Dr 1 and social services. No detail was written about these discussions.

Dr 1 subsequently contacted the GP and health visitor after the child had left hospital but little detail was recorded in relation to this conversation.

Dr 3 was happy to let the parents go home.

He did not record any explanation for the bruising seen or his opinion regarding the bruising.

At interview he reported that he advised the parents about careful handling. This implies that he thought the parents had applied excessive force to the baby's leg in routine handling. No follow up was arranged.

It was not evident from the medical notes if Dr 3 and Dr 1 discussed their individual concerns and opinions. From the interviews it was clear that Dr 1 did not think that a plausible explanation had been offered for the injuries seen. Dr 1 did not challenge Dr 3's opinion. At interview Dr 3 recounted "talking to Dr 1" but did not allude to them having a difference of opinion at this time.

Dr 3's decision changed the planned course of events for Baby Persona l informati.

Dr 1 had arranged a skeletal survey and CT scan of brain to be carried out on Baby Persona l informati on the basis of unexplained bruising in a pre-mobile child but bowed to his colleague's experience and position in terms of child protection and cancelled the radiological investigations that he had arranged.

3. Subsequent Actions within Acute Paediatrics

A number of retrospective notes were written in the medical notes following the baby's discharge from hospital on the [redacted].

Dr 1 wrote on [redacted] his involvement with the case from [redacted] through to the [redacted].

He stated that in collaboration with Dr 3 he had concluded that the bruises represented "a presumed accidental or incidental cause for bruising…perhaps on strapping to car seat or handling".

Dr 1 made reference to the prompt and appropriate attention from both parents to the baby (this was not the case as the parents had not prompted the referral to the GP).

Dr 1 had further discussions with the baby's GP and health visitor on [redacted].
Dr 1's notes were the first in a series of retrospective notes written by ward staff on the [redacted] following the baby's discharge from hospital.

Dr 3 reported during interview that he was not aware of the notes that had been written following the baby's discharge and that no-one had approached him to discuss their on-going concerns.

Dr 1 was still concerned about this case on [redacted]. He had been contacted by the Child Protection Nurse Specialist on the morning of the [redacted] during the ward round and met with her at lunchtime. She was concerned that the correct procedures had not been followed when investigating unexplained bruising in a pre-mobile child. Dr 1 said that he could not explain the bruises and they were presumed accidental. Dr 1 had on-going concerns about this case that had been stirred by his discussion with the CPNS.

Later on the afternoon of [redacted] Dr 1 had an informal meeting with a senior nursing colleague, Dr 6, nurse 3 and 5 and the hospital social worker. He reports a general discussion took place in relation to child protection practices in the ward and Baby [redacted]. The hospital social worker advised that a UNOCINI had been completed in respect of Baby [redacted]. This was for information only. Dr 1 reported at interview he was reassured by this, however he did not appreciate that the UNOCINI was for information only. At interview Dr 1 reported that staff agreed that in future cases of a pre mobile baby they would take a different course of action for example, completing more diagnostics and completing a UNOCINI.

Analysis of subsequent actions following discharge

In many cases it is advantageous to have a team member who can see through the emotion that staff experience at the frontline of child protection work. It is difficult for many people working with children and parents/carers to alter their relationship with

parents/ carers from one of working with them for the child's benefit to one of having to adopt a more forensic and inquisitorial approach. Child protection policies and procedures are designed to give all professionals working with children clear guidance as to how to proceed when abuse is suspected. There is a need for professionals to step back from their relationship with parents/carers and focus on the paramountcy of the child. A safeguarding professional further removed from the frontline, whose opinion is valued in the team, can often provide this clarity and support in emotive and complex situations.

Analysis

These retrospective notes suggest that for medical and nursing staff and social workers the issues raised by this case had not been resolved by the baby's discharge from hospital.

There was a lack of clarity as to how to resolve these issues. Senior medical and nursing staff demonstrated confusion about how and who could make a referral on a child about whom there were safe guarding concerns. Case management lacked direction and the notes convey a state of confusion.

5.1.6 Child Protection Nurse Specialist (CPNS)

The CPNS was present on the ward when Dr 7 received telephone call from Dr 4 advising that the GP was sending Baby Personal Information redacted by the USI (Personal Information redacted by the USI) for assessment due to unexplained bruising. The CPNS briefly highlighted that bruising in pre mobile baby was suggestive of possible non accidental injury and advised nurses 3 Nurse 4 and Nurse 5 to commence UNOCINI, inform hospital social worker and update CPNS following Personal Information redacted by the USI 's admission to ward. The CPNS advised nurses on the Ward to liaise with named Health Visitor. The CPNS also advised the community locality based CPNS of Personal Information redacted by the USI 's admission and assessment.

On Personal Information redacted by the USI , at 15.10 the CPNS contacted the ward by telephone for an update in respect of Personal Information redacted by the USI . Nurse 5 advised that Baby Personal Information redacted by the USI was discharged the previous evening with medical advice for parents to return with Personal Information redacted by the USI in the morning.

Nurse 5 further advised Personal Information redacted by the USI 's Blood results were normal, the CPNS asked if a skeletal survey had been undertaken and was advised this had not been completed. Nurse 5 reported that Mum and Dad were very appropriate with Personal Information redacted by the USI .

CPNS stated that in her opinion a skeletal survey was required and also requested Nurse 5 to complete UNOCINI referral. Nurse 5 advised that Nurse 3 was due on night duty that evening and had been more involved in the case and would therefore be better placed to complete referral. The CPNS agreed to make contact with nurse 3 that evening

At 21.45 pm Personal Information redacted by the USI the CPNS contacted Nurse 3 to discuss concerns and clarify progression of UNOCINI. The CPNS advised nurse 3 she was not happy as Personal Information had been discharged home without a skeletal survey and other investigations to determine the cause of bruising. She advised Nurse 3 to complete a UNOCINI.

Nurse 3 advised that Baby Personal Information had been seen by three consultants and further investigation was not deemed necessary. The parent/child interaction was reported as being very positive and that she had no concerns. Nurse 3 advised she did not feel that a UNOCINI referral was necessary. The CPNS advised she was not in agreement and would discuss with Named Nurse for Safeguarding and Nurse 4 in the morning. The CPNS escalated her concerns to the Named Nurse for Safeguarding and the Head of Health Visiting and School Nursing on the Personal Information redacted by the USI. Actions taken by the community senior management team following this escalation are outlined in section 5.1.8 of this report.

On Personal Information redacted by the USI the CPNS requested to speak with Dr 1 to clarify his assessment and reason for bruising when he reviewed baby Personal Information on Personal Information redacted by the USI on the ward. She also requested to confirm if skeletal survey had been completed and if so what the result was. Dr 1 maintained the injury was accidental.

Analysis

The role of the CPNS within the Southern Trust is to promote good professional practice within the organisation and to provide advice and expertise for nurses and midwives regarding safeguarding concerns and expected standards of practice. The role of the CPNS, as outlined in regional child protection policies and procedures, is clearly central to advice and guidance on safeguarding issues to nursing staff but the role is not designed for them to have hands on clinical input, and this is important in maintaining objectivity.

It is clear that the CPNS provided clear sound guidance on in keeping with the regional trust policies and procedures to nursing staff that they should commence a UNOCINI referral to the Gateway service and inform the Hospital Social Worker due to bruising being evident in a pre-mobile baby. The CPNS appropriately escalated this case to her line manager on Personal Information redacted by the USI on learning that Baby Personal Information had been discharged home to the community on Personal Information redacted by the USI without a referral to social services being progressed. The review team believed that the CPNS acted appropriately throughout.

Although the CPNS used her line management to escalate concerns to Dr 1 the review team considered that a mechanism should have been in place to escalate within the acute sector, for example, the Clinical Director and Head of Paediatric Services to enable rapid multi-disciplinary discussion and decision making in the case.

5.1.7 Hospital Social Work (HSW)

The Hospital Social Worker (HSW) was aware of the admission of Baby Personal Information redacted by the USI on the Personal Information redacted by the USI as she was in discussion with the ward about another case and was also informed about the imminent admission of Baby Personal Information redacted by the USI for assessment relating to unexplained bruising. The HSW undertook checks to establish if there were other children in the family and to see if Baby Personal Information redacted by the USI was known to Social Services. On interview she recalls stating to the ward staff that unless the bruising is very well explained, he cannot go home. The HSW also noted and recorded that there were three (at that stage) explanations from the parents on how the bruising may have occurred.

On the following morning, Personal Information redacted by the USI, whilst on the ward reviewing Personal Information redacted by the USI's records the HSW recalled at interview that she expressed her surprise that Baby Personal Information redacted by the USI had been allowed to go home especially as the blood tests were clear. She states she queried with Dr 3 why he had been allowed to go home. She recalls that Dr 3 stated that he was trying to work with the family and that he had consulted with other Doctors. The HSW was aware that the family were due on the ward at 10.30am and when they were late, she advised Nurse 5 to ring them. The HSW also rang the Gateway Team in Dungannon to alert them of the possible NAI. She also stated that she assumed that a UNOCINI had been completed by the Health Visitor and therefore Gateway would be aware of the case from the previous day. Gateway had no knowledge of this case however, the HSW states that she assumed this was due to the paperwork taking time to come through from the Armagh Gateway team which is the single point of entry for referrals in the Southern Trust.

Following the assessment of Baby Personal Information redacted by the USI, by Dr 1 and Dr 3, the HSW stated she was informed there was no pattern to the bruising, and the injury was seen as accidental due to poor handling. The HSW had recorded a plan for the nursing staff to let the Health Visitor know re discharge and for them to determine if the UNOCINI was done. The HSW states she had on-going concerns about bruising on a non-mobile infant and sought advice from her line manager on Personal Information redacted by the USI.

The HSW remained unclear as to whether a UNOCINI had been completed or not. Therefore following advice from her line manager a UNOCINI was filled in on Personal Information redacted by the USI by the hospital social worker and sent to Gateway for information only. Although non-accidental injury was queried on this referral there was no information entered as to whether immediate actions were necessary to safeguard Baby Personal Information redacted by the USI and there was lack of clarity in relation to parental consent for referral

Analysis

It is the opinion of the review team that the degree of confusion over the status of the UNOCINI referral and the issue of consent was not helpful and that this should have been clarified much sooner than it was. It was the opinion of the review team that this should have been co-ordinated by the HSW.

The review team acknowledge that the HSW challenged the decision to allow Baby Personal Information redacted by the USI home on the Personal Information redacted by the USI. The HSW did not challenge Dr 1 and 3 on the Personal Information redacted by the USI

Personal Information redacted by the USI, as she states that this was a medically led decision. However the review team considered that an opportunity was missed by the HSW to consider the presenting risks, i.e., bruising on a pre-mobile baby, the parent's insistence on leaving the ward the previous evening and the variation in explanations provided for the bruising. It was also clear that the HSW continued to have concerns and she sought advice from her line manager. This subsequently lead to her completing a UNOCINI to Gateway but the reason for her UNOCINI referral was for information only and the risk factors associated with unexplained bruising on a pre-mobile baby were not highlighted. The UNOCINI was received by Gateway and logged as information only.

5.1.8 ROLE OF COMMUNITY SENIOR MANAGEMENT ON Personal Information redacted by the USI

Due to her clear advice to complete a UNOCINI not being progressed and concerns about Baby Personal Information's discharge the CPNS escalated her concerns to the Named Nurse for Safeguarding on Personal Information redacted by the USI and subsequently these were raised with the Head of Health Visiting and School Nursing, Assistant Director of Safeguarding and Assistant Director of Specialist Child Health and Disability on Personal Information redacted by the USI. At this time, the Assistant Director of Family Support and Safeguarding was not provided with information that a non-accidental injury was indicated by the professionals who had direct contact with baby Personal Information and family, nor that a decision had been made that the child protection threshold was reached. In the absence of being informed that the threshold for child protection was achieved (as stated in the Children Order (NI) 1994 and the Regional Child Protection Policy and Procedures 2005 "a child who is suffering or likely to suffer significant harm"), the Assistant Director of Family Support and Safeguarding advised that a child protection referral, submitted via UNOCINI, could not be progressed. The CPNS was therefore requested to return to the ward the next day and discuss the on-going concerns with Dr 1.

The CPNS did meet with Dr 1 to discuss the concerns and her discussions with senior management. Dr 1 confirmed that he was satisfied with the decision made following the outcome of the assessment on Personal Information redacted by the USI. Following this meeting, the Assistant Director of Family Support & Safeguarding, Head of Service for Health Visiting and School Nursing, Head of Acute Paediatric Services and the Governance Manager agreed to undertake a Root Cause Analysis of the case to examine the process of the decision making and that Baby Personal Information had been discharged into the community without a referral to Social Services. This process never commenced due to the subsequent serious injuries to Baby Personal Information on Personal Information redacted by the USI.

Analysis

The review team considered that the Assistant Director of Family Support & Safeguarding in consultation with the Head of Health Visiting and School Nursing and the Assistant Director of Specialist Child Health and Disability made the correct decision in respect of UNOCINI referral at that time. The Review Team are of the view that this was compliant with local and Regional Child Protection Policy and Procedures.

However, the review team are recommending that there should be a mechanism in place to escalate acute child protection issues within the acute hospital setting, and that this should be done while the child/young person remains in this place of safety. This will be addressed within the recommendations.

5.1.9 Analysis of the bruising on Baby [redacted]

This analysis is based on the photographs taken of Baby [redacted]'s bruising as he presented to the professionals on [redacted]. These photographs have been analysed by the Independent Consultant Paediatrician and the Consultant Paediatrician on the review team.

There were 2 photographs of the posterero-lateral aspect of the right leg. There appeared to be two large areas of bruising to the right leg, however it may be that this is in fact be one area of continuous bruising. The first bruise extends from the upper thigh on postero-lateral aspect of the leg to just above the knee. There also appears to be a linear abrasion on the posterior thigh which extends from upper to mid-thigh. The second area of bruising extends from the postero-lateral aspect of the right knee to the mid-calf. The photographs suggest the bruising has a linear quality.

The analysis is that the pattern of bruising would suggest a hand grip or possibly a slap mark and would be consistent with a non-accidental injury.

6.0 Conclusion

This is a tragic case of a [redacted] old baby boy who was initially presented to hospital with significant bruising to his right leg. No clear mechanism was identified for the bruising and no bleeding disorder was found on blood testing. Four days following his discharge from hospital he was brought by ambulance to the Emergency Department critically ill with evidence of extensive intracranial bleeding from which he subsequently died.

Neuropathology examination is pending to exclude any congenital or vascular abnormality that may have led to the bleeding within this baby's brain.

Physical abuse must be considered as a likely cause for the initial presentation and at this stage in the investigation a possible cause for the catastrophic events that followed. Since the death of Maria Colwell (1973) legislation, policies and procedures have been created over the years to provide a framework for child protection to which is a multi-disciplinary process necessitating joint decision making, planning and intervention. The Southern Trust provides a comprehensive multi-disciplinary child protection training programme including UNOCINI, mandatory Child Protection and Recognition and Response courses (this is not an exhaustive list). As well as implementing regional policies and procedures, the Trust developed an Admission and Discharge Policy

making the services Laming compliant. This policy includes guidance if there is disagreement on a case and on how to escalate these concerns/disagreements. The Trust has also implemented policy's locally such as the Graded Care Profile (multi-disciplinary assessment of Neglect) and the Safeguarding Policy for Nursing staff. Therefore, the review team did not identify a gap in the provision of policy and procedures or training but instead that staff had not adhered to or referred to policies and procedures.

In addition to the ongoing training programme available to all staff, the Trust have also provided a comprehensive four day training programme for all senior acute hospital nurses in October 2012 which revisited safeguarding issues, signs and symptoms, recognising and responding to safeguarding and making a good quality UNOCINI referral.

Despite this, some nursing and medical staff involved in this incident still expressed issues in relation to roles and responsibilities, specifically the role of general nursing staff and CPNS, being adequately equipped to deal with child protection in an acute setting, and thresholds for instigating child protection investigations. One medical staff member expressed his opinion regarding on-going broader difficulties within the Acute Sector of the Directorate of CYP and senior management team despite the work undertaken by the Trust to improve working relationships and to address the concerns raised about the role of the CPNS.

Some staff appeared to be unaware of fundamental safeguarding issues such as signs and symptoms and processes such as obtaining Police Protection Orders/Emergency Protection Orders. Although concern about Baby [redacted]'s bruising were considered by a number of the professionals involved, they appeared to act in a counter-intuitive manner and the concerns were deferred throughout this process. This case also highlighted the inadequate recording by a number of the professionals either by absence or quality of recording and by absence of evidenced based decision making.

The review highlighted a number of failings, to a greater or lesser extent, with the majority of the professionals involved. These can be grouped into the following themes:

- Failure to recognise the significance of bruising on a pre-mobile baby. This prevented non-accidental injury as a cause of the bruising being robustly explored.

- Interaction with the family appeared to be influenced by the parents' demeanour, professional, martial and social status and their "appropriate manner" with their son. At no stage was the issue of non-accidental bruising discussed with the parents directly. Practically all of the professionals who were interviewed described how appropriate the parents appeared. This clouded the professionals analysis and decision making and appeared to prevent them from considering the significance of the parents specific behaviour, most particularly:

1. Their insistence on leaving the ward on the night of the [redacted] and their readiness to sign a CTMA form.
2. The variance in the explanations for the bruising. By the time Baby [redacted] was discharged on [redacted], there had been 5 different reasons provided.
3. The variance regarding when the parent's first observed the bruising.

- Non-compliance with Regional and local guidance and policy and procedures such as Co-operating to Safeguard Children (DHSSPS 2003), Regional Mutt-disciplinary Child Protection Policy and Procedures (DHSSPS 2005, 2008), SHSCT Nursing Safeguarding Policy, SHSCT Admission, Assessment & Discharge Policy & Procedures for CYP about whom there are Safeguarding Concerns (2011), UNOCINI (Understanding the Needs of Children in Northern Ireland) Assessment Framework Guidance (2011).

- There was a failure to adhere to Safeguarding reporting arrangements

- Record keeping. There were a number of issues highlighted during this review regarding documentation such as retrospective recording. The most significant concern however, was the lack of recording by staff.

  1. Failure to record events, observations, directions, instructions and follow ups.
  2. Extensive use of retrospective, non-contemporaneous recording.
  3. Absence of rationale and evidence for decision making in recording particularly with regard to the assessment of Baby [redacted]'s bruising.

- Lack of multi-disciplinary decision making. This review highlighted that the decision to discharge [redacted] and assess his bruising as Accidental was led by a single discipline.

7.0 Recommendations

General Recommendations

Training

1. A re-emphasis on acute mandatory multi-disciplinary training to address the challenges created by a hierarchal system within professions and the natural propensity for less senior practitioners to defer difficult decisions and conversations to more senior colleagues This training must encompass the issues raised within the analysis of this case and will continue to focus on :

    - Review of multidisciplinary training in Recognising and Responding to Signs and Symptoms of Child Abuse.
    - Physical Injuries Workshop.
    - Continued monitoring of attendance at UNOCINI Training. This training addresses the barriers which health professionals experience in acting on child protection concern thus enabling more effective communication with family/parents and other disciplines.

2. The training will be accompanied by mentorship and supported peer review provided by the CPNS and Named Nurse for Safeguarding and Named Doctors.

3. An audit of practice will be developed and will be on-going.

Policies and Procedures

1. Safeguarding Policies and Procedures are in place, however the review team have identified the further areas where procedures should be developed following the learning from this review.

2. An additional guidance in relation to medical photography when physical abuse is suspected in children.
3. An augmented procedure and escalation for multidisciplinary case discussion and how to deal with differences in opinion and escalate these if they are not resolved by discussion will be added in a more specific manner i.e. escalation to Clinical Director and Head of Service

4. A working Group will be established to develop a procedure which specifically encompasses multi-disciplinary management of bruising on pre-mobile babies to include a pathway of referral.
5. The "Pathway when child protection procedures are required" (a checklist) contained within the nursing admission and the discharge checklist from within SHSCT "Admission, Assessment and Discharge Policy and Procedures for Children and Young People about whom there are Safeguarding Concerns" are contained within 2 separate documents. These documents should be reviewed and amended. Roles and responsibilities in relation to this document are to be defined.

Documentation

1. Contemporaneous recording to be addressed in addition to the appropriateness of non-contemporaneous recording
2. Specific training on recording, data storage and child protection should be accessed for all professions and attendance monitored

Roles and Responsibilities

1. The review team recommend that there are clear roles, responsibilities and accountability in relation to the general acute paediatric team, Senior Managers, the CPNS, the Hospital Social Worker and the Named Doctor to prevent a repeat of the deferment that was evident in this case. This should be agreed by all stakeholders. The outworking of roles and responsibilities should then be included in the audit of multi-disciplinary practice.

2. The first person identifying the injury in a pre-mobile baby should make a UNOCINI referral to Gateway.

Working Relationships

1. The review team recommend that additional work will be undertaken to examine and resolve any difficulties in working relationships between the acute clinical team and Children and Young People's senior management.

<u>Profession Specific Recommendations</u>

Health Visiting

1. Health Visitors must endeavour to have at least one face to face contact with the father of the child to complete a holistic Family Health Assessment.

2. Health Visitors to complete a detailed body map in all cases of suspected/confirmed NAI.

3. Health Visitors who observe bruising on a pre-mobile baby must immediately make an appointment with the GP and ensure that parent/carer and baby attend the appointment.

4. Health Visitors must speak directly to the GP regarding child protection concerns and share any other relevant information and provide a written referral outlining concerns

1. Acute Nursing

- The first three points within the discharge checklist contained in the SHSCT "Admission, Assessment and Discharge Policy and Procedures for Children and Young People about whom there are Safeguarding Concerns", appear to relate to actions that should be taken on admission. Consideration should be given to moving these actions to a safeguarding checklist (to include both admission and discharge) as per previous point.

Medical

1. Specific training for medical staff to recognise barriers (refer to appendix 1) on responding to child protection concerns.

2. Key clinical decisions in relation to child protection must be taken by a multi-disciplinary team with the child's safety as paramount.

3. Where doubt exists in relation to clinical findings the decisions must be taken in favour of safeguarding the child.

4. Unexplained findings suspicious of non-accidental injury must be subject to rigorous multi-disciplinary discussion.

Primary care

1. While the review team do not have authority to make recommendations in relation to Family Practitioners, representatives of the review team will meet with the HSCB/PHA to share the relevant learning from this case.

8.0 Learning from SAI in relation to Baby [redacted]

Policies and procedures are in place nationally, regionally and locally to guide medical staff in the recognition and response to the signs of physical abuse in infants and children.

In this case these procedures were not followed.

There were barriers to recognising that the bruises seen on this baby could have been caused by abuse and the response was therefore fragmented and confused.

Similar barriers have been recognised in other cases [4,7] and are highlighted in publicised guidance [8,9] and in appendix 1.

9.0 Dissemination of learning

The learning from this case will be shared in all appropriate foras and forums across the Trust. The learning will also be shared with the HSCB and the Safeguarding Board of Northern Ireland as there is regional learning in the significance of bruising with a pre-mobile infant.

References

1. Area Child Protection Committees' Regional Child Protection Policy and Procedures April 2005 http://www.dhsspsni.gov.uk/acpcregionalstrategy.pdf

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3. The Children (Northern Ireland) Order 1995 http://www.legislation.gov.uk/nisi/1995/755/contents

4. The Victoria Climbie Inquiry by Lord Laming January 2003

5. Sugar NF, Taylor JA, Feldman KW. (1999) Bruises in Infants and Toddlers: Those who don't cruise rarely bruise. Puget Sound Paediatric Research Network. Archives of Paediatric and Adolescent Medicine; 153(4)339-403

6. Labbe J.M.D. Caoutte G. (2001) Recent skin injuries in normal children. Paediatrics 108(2):271-6

7. Local Safeguarding Board Haringey. Serious Case Review: Baby P. Executive Summary February 2009. http://www.haringeylscb.org.executive_summary_peter_final.pdf

8. Safeguarding Children and Young People: A Toolkit for General Practice (2009) Royal College of General Practitioners and National Society for the Prevention of Cruelty to Children

9. Keep me Safe: RCGP strategy for Child Protection 2005

APPENDIX 1

Common themes include:

1. **Belief that child abuse is not a common problem.**

2. **Failure to recognise that bruising in infants is a strong indicator of abuse when medical conditions have been excluded.**

3. **A tendency to seek more comfortable explanations for observations.**

4. **A perception that child abuse is more likely to occur when there are overt signs of parental difficulties, such as; mental health issues, domestic violence, drug and alcohol addiction or if parents are from deprived socioeconomic backgrounds.**

5. **Fear of disapproval from parents and concerns that unfounded allegations of abuse will result in complaints and litigation.**

6. **Underestimating the problem – failing to recognise the danger to a child**

7. **Not adhering to the principle of paramountcy of the child**

8. **Uncertainties about reporting procedures**

9. **Lack of a multidisciplinary approach**

Stinson, Emma M

From: McCooey, Blaithnid <[redacted]>
Sent: 24 January 2012 15:40
To: Black, Tony; Cardwell, David; Kerr, Vivienne; Leyden, Francesca; Marshall, Margaret; McGuigan, Caroline; McKeegan, Elaine; Morrison, Denise; Reid, Cathrine
Cc: Burns, Deborah; Magennis, Joscelyn
Subject: SMT Governance papers
Attachments: Ombudsman Update 01.10.2011 - 31.12.2011.doc; final. SAI report - 31.12.2011.doc; SAI Overview Table.docx

Hi all;
Please see attached for your perusal some of the papers for tomorrow's Governance SMT.
Please come back to me with anything you feel needs queried.
Apologies for the short notice and for the fact that not all the papers are attached; As we had some delays in reports being run etc this simply could not be avoided.

Many Thanks,
Blaithnid

Blaithnid McCooey
Governance Officer
Corporate Clinical & Social Care Governance Office Trust Headquarters College of Nursing CAH Site
68 Lurgan Rd
Portadown
BT63 5QQ

t: [redacted]
f: [redacted]
e: [redacted]
(Hours of work: 9am-5pm Mon-Fri)

Southern Health and Social Care Trust

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Update on Cases with N.I. Commissioner for Complaints

Position as at December 2011

Introduction

This report provides Governance Committee with a summary of the number and nature of cases with the Ombudsman and a summary of the outcomes within the period 1 October 2011 to 31 December 2011

TABLE 1 - CASES WITH OMBUDSMAN'S OFFICE AT 31 December 2011

Date letter received from Ombudsman's Office	Patient/Client Identification	Directorate	Nature of complaint	Current position	Additional Comments/ Progress Update
8 June 2009	01/09	OPPC	Care and treatment provided to aunt	On-going	4 April 2011 - Letter received from Ombudsman regarding issues raised in Trust correspondence under consideration. 27 June 2011 – Letter from Ombudsman advising that investigation of the issues raised in this complaint is continuing. 19 September 2011 - Trust received Ombudsman's letter together with Draft copy of Investigation Report. Comment/response on Draft Report from the Trust by 7th October 2011.

					13 December; finished report sent to Trust and also sent to complainant. Ombudsman Office states no further investigation on their part however payment of Irrelevant information redacted by the USI to be issued from Trust to complainant along with letter of apology and Trust to address compliance issues from within.
29 July 2010	05/10	MHD	Treatment and quality of care given to father by staff	On-going	31 May 2011 Letter from Ombudsman to Trust advising that preliminary investigation into the issues raised by the complainant are continuing. 8 August 2011 Letter from the Ombudsman to the Trust which made reference to a list of guidance/reports, eg. The National Service Framework for Older People and asked the Trust to confirm if adopted/applied any equivalent guidance/reports. Trust to reply to Ombudsman before 22 August 2011.

					19 August 2011 Trust responded to Ombudsman letter of the 8th August 2011. 10 September 2011 Letter from Ombudsman to Trust advising preliminary investigation still continuing. Letter to SH&SCT from Ombudsman dated 21 December 2011, enclosing draft copy of the Investigation report and welcoming any additional comments from SH&SCT. Letter from Trust to Ombudsman dated 20.01.2012 stating that the Trust accepts the Commissioner's report as factually accurate and accepts the conclusions and findings as laid out within the Report and will continue to take the appropriate actions to address the failings identified.

2 February 2011	01/11	Acute	Wife complaining about quality of treatment given to her husband.	On-going	Trust has provided background information to investigation. 26 July 2011 Ombudsman contacted The Trust providing a progress update – stating some aspects warrant further investigation before progressing to a formal investigation. Ombudsman requested Trust's comments on IPA statement. 09 September 2011 Trust responded to Ombudsman Letter of the 26 July 2011. 14 September 2011 Ombudsman acknowledged Trust's letter dated 9 September 2011. 20 December 2011; Draft copy of the investigation report received to SH&SCT from Ombudsman. The cover letter invites the SH&SCT to comment on any of the proposed findings and conclusions and issue any concerns in writing after which an informal meeting can take place if desired.

					The Trust has requested an Extension until 01.02.2012 with regards this Case and the Ombudsman has approved this.
23 August 2011	04/11	Acute	Complainant claims to have sustained injustice as a result of maladministration by the Trust. Issues in relation to care at A&E, and waiting time for services	On-Going	23 August 2011 Ombudsman letter to Trust notifying of complaint and issues identified. Requesting Trust response before 21 September 2011. 22 September 2011Trust response to Ombudsman letter of the 23 August 2011. 28 November 2011, letter from Ombudsman outlining two questions which the Trust was asked to respond to by 21 December 2011.

					Response issued to Commissioner from Trust on 12 December 2011, acknowledged 16 December 2011.
7 September 11	05/11	Acute	Spouse concerned in relation to wife's admission to A&E and the level of treatment and care experienced by complainant and spouse.	On-Going	7 September 11 Letter from Ombudsman to Trust advising of concerns of complainant. Initial Trust response issued to Ombudsman on 20 October 2011. .
14 December 2011	N/a	MHD	Lady feels suffered injustice as a result of maladministration by SH&SCT Lady feels she was unnecessarily detained on 15 January 2008 for 17	New Case	14 December 2011, Letter from Ombudsman to SH&SCT outlining issues of Complaint and requesting a response with the required information to be with Commissioner within 30 working days, I.e. 30 January 2012.

			days at Personal Information redacted by USI and also that the Trust holds incorrect information within her Medical Notes.		
16 December 2011	N/a	OPPC	Patient claims that he received a phone call to state his Meals on Wheels Service was to be stopped before any re-evaluation of his needs was carried out.	New Case	Response to be with the Ombudsman by 11 January 2012. Extension granted until 23 January 2012. Response letter to Ombudsman sent on 23.01.2012.

Table 2 - Cases closed by the Ombudsman 1 October 2011 – 31 December 2011

During the period above there were 6 cases closed by Ombudsman.
The Trust was instructed to pay consolatory payments in respect of 1 of these cases.

Date letter received from Ombudsman's Office	Patient / Client Identification	Directorate	Nature of Complaint	Current Position	Additional Comments / Progress Update
14 June 2010	03/10	ACUTE	Issues re treatment and care received in Craigavon Area Hospital	**Closed**	28 April 2011 – Trust apology letter forwarded as advised by ombudsman. 4 August 2011 Ombudsman letter to Trust advising that complainant has made Ombudsman aware of further issues of complaint, which were part of the commissioner's previous investigation. The Ombudsman has requested further comment from the Trust. 9 September 2011Trust letter to Ombudsman clarifying points raised.

					22 September 2011 Ombudsman acknowledged receipt of Trust letter dated 9 September 2011. Ombudsman has requested independent medical advice to assist in investigation. Ombudsman investigation still current. Letter received to SH&SCT on 9 November 2011 to state that based on the information provided by the Trust previously, the Commissioner had decided to take no further action in relation to the complaint and a letter stating same was sent to the Complainant.
28 July 2009	02/09	CYP	Financial issue and level of assistance provided by Trust to Family	Closed	21 April 2011 Trust asked for 4 week extension to reply to Ombudsman letter due to complexity of issues. 07 June 2011 Trust responded to Ombudsman

					16 August 2011 Letter from Ombudsman acknowledging receipt of Trust's response advising that no decision taken as yet re complaint. 22 August 2011 Letter from Ombudsman advising that he has decided that there are aspects of Mr Personal Information redacted by the 's complaint which warrant further investigation. To proceed with formal investigation. 13 September 2011 Draft report received from Ombudsman for comment by the Trust before 5th October 2011. Final Report from Ombudsman sent to both Complainant and the Trust on 13.12.2011. Trust to follow-up with a letter of apology and take on-board any learning recommendations.

28 September 2010	07/10	OPPC	Withdrawal of meal delivery service	Closed	15 April 2011 – Trust responded to Ombudsman's request of the 30 March 2011. 6 May 2011 Ombudsman letter to Trust enclosing a copy of the findings of the preliminary investigation which states the Commissioner is suggesting to the complainant Ombudsman's intention not to investigate complaint further. 23.01.2012, Ombudsman confirmed case has been closed.
2007	01/07	CYP	Adoption Issue	Closed	11 May 2011 - Letter received from Ombudsman requesting further information. Trust responded to this on 26 May 2011 and requested a 4 week extension. On 23 June Trust responded to request for further information. 26 September 2011 – Letter received from Ombudsman acknowledging Trust response dated 23 June 2011 and

					attaching investigation report for comment by the Trust – target response date 4 October 2011. Ombudsman also sent to Trust a letter and a copy of Draft Report for the attention of Family Care Society for his comments. On 28th September 2011 the Trust requested an extension of 4 weeks to be added onto the quoted response date of 4 October 2011 to enable the Trust to formulate a response due to the complexity of the case. A letter from SH&SCT was generated on 29th December 2011 to the complainant, stating that in relation to the report which they would have received from the Ombudsman dated 16th December, the CYPS would now take action to ensure that a payment of Irrelevant information redacted by the would be issued. There was also an apology on behalf of the (legacy) CBCT for the treatment the

					complainant had received and a pledge that the SH&SCT would take on board all learning from the said case. A Cheque was issued to the complainant on 13.01.2012.
3 September 10	06/10	HR	Allegations of financial abuse	Closed	11 October 2011 Letter from Ombudsman to Trust advising that they are taking no further action and have advised complainant accordingly.
15 July 11	02/11	Acute	Treatment given to father and alleged failure of Trust communication with family	Closed	Letter received by Trust from Ombudsman dated 19 October 2011 explaining that the Commissioner has considered the information provided by the Trust and has decided to take no further action in relation to this complaint.

Southern Health and Social Care Trust

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SERIOUS ADVERSE INCIDENTS REPORT

01 April 2011 – 31 December 2011
Financial Year 2011/2012

Governance Committee
7th February 2012

Introduction

The Trust has in place arrangements in keeping with DHSSPS guidance. Reporting of all Serious Adverse Incidents continues in accordance with the Southern Health & Social Care Trust Policy *'Actions to be taken when a serious Incident Occurs'*. Monitoring of Serious Adverse Incident reporting continues to be coordinated through the Chief Executive's Office to ensure timely reporting and follow up.

1. Description

This report provides a summary of the Serious Adverse Incident's reported during the period 01 April 2011 – 31 December 2011 and those Serious Adverse Incidents that remain open from 01 April 2007 – 31 December 2011.

Index of Tables/Figure:

Table 1 – SAIs which remain open from 01 April 2007 – 31 March 2011

Date SAI Reported	SAI ID	DIRECTORATE	DESCRIPTION	DETAIL	No of Weeks before Report Submitted
28/09/2007	Personal Information redacted by the USI	Acute	Maternal Death	DRO requested additional information. Vulnerable Adults Policy sent to Board. SHSCT awaiting Dr Farrell to close.	16 weeks
26/10/2007		Acute	Maternal and Child Death	Awaiting decision from Board re closure.	39 weeks
24/08/2009		CYP	Unexpected Child Death	Awaiting decision from Board re closure.	26 weeks
13/11/2009		MH&D	Suspicion of homicide	Sent to Board on 27/05/2010	27 weeks
04/03/2010		CYPS	Safety of care re cross border issue - young child	Submitted to Board 21/07/2010. Joint review by SHSCT & NEDOC -cross border	21 weeks
23/04/2010		MH&D	Suspected suicide	Submitted to Board 18/08/2010	16 weeks
14/06/2010		Acute	In-patient death (on drug trial)	Submitted to Board 07/10/2010	16 weeks
02/09/2010		Acute	Retained surgical swab Research trial	Submitted to Board 07/01/2011	18 weeks
04/10/2010		Acute	Maternal death	Submitted to Board 15/11/2011	58 weeks
28/10/2010		MH&D	Sexual assault	Submitted to Board 15/02/2011	15 weeks
02/11/2010		Acute	Failed equipment	Submitted to Board 27/01/2011	12 weeks

Date SAI Reported	SAI ID				
	Personal Information redacted by the USI				
14/12/2010		MH&D	Allegation of rape	PSNI Inves. 14/6/11 Submitted to Board 15/6/11	30 weeks
24/02/2011		OPPC	Allegation of theft	Submitted to Board 14/11/11	37 weeks
28/02/2011		LD	Alleged Abuse	Submitted to Board 21/07/2011	20 weeks
28/02/2011		OPPC	Allegation of theft	Submitted to Board 21/07/2011	20 weeks
15/03/2011		Acute	Death of Child	Submitted to Board 14/06/2011	13 weeks
09/02/2011		CYPS	Allegation of rape	Submitted to Board 04/11/2011	38 weeks
09/03/2011		MH&D	Death of Client due to choking on food	Submitted to Board 18/08/2011	24 weeks

Table 2 – Overview of notified SAIs for period 1 April – 31 December 2011

April – December 2011					
Nature of Incident	**Acute**	**CYPS**	**MHD**	**OPPC (Inc.OOH)**	**Total SAIs per Nature of Incident**
Suicide Related		1	7		8
Assault/ Aggression/ Allegations - patient to patient			1		1
Adult Death	5		2	1	8
Sudden Child Death	1*	2			3
Infant Death	2				2
Allegation of Sexual Abuse		2	2		4
Other	3	2	2	1	8
Total SAIs per Directorate	11	7	14	2	**34**

***ACUTE Directorate** - Sudden Child Death SAI deescalated.

Table 3 – Breakdown of '*other*' category (Nature of Incident) for Quarter 1 - 3, SAI reporting period: 1 April – 31 December 2011

*Break Down of Other Category (April – December 2011)				
Nature Of Incident	**Acute**	**CYPS**	**MHD**	**OPPC (Inc OOH)**
Fire incident				1
Alleged Homicide			1	
Threats to Kill and False Imprisonment		1		
Self-Harm Related Incident			1	
Inappropriate Restraint		1		
Unnecessary Scans/Recording Errors	2			
Intra Hospital Transfer of Adult	1			

Figure 1 – Breakdown of total number of notified SAIs reported by Directorate April – December 2011

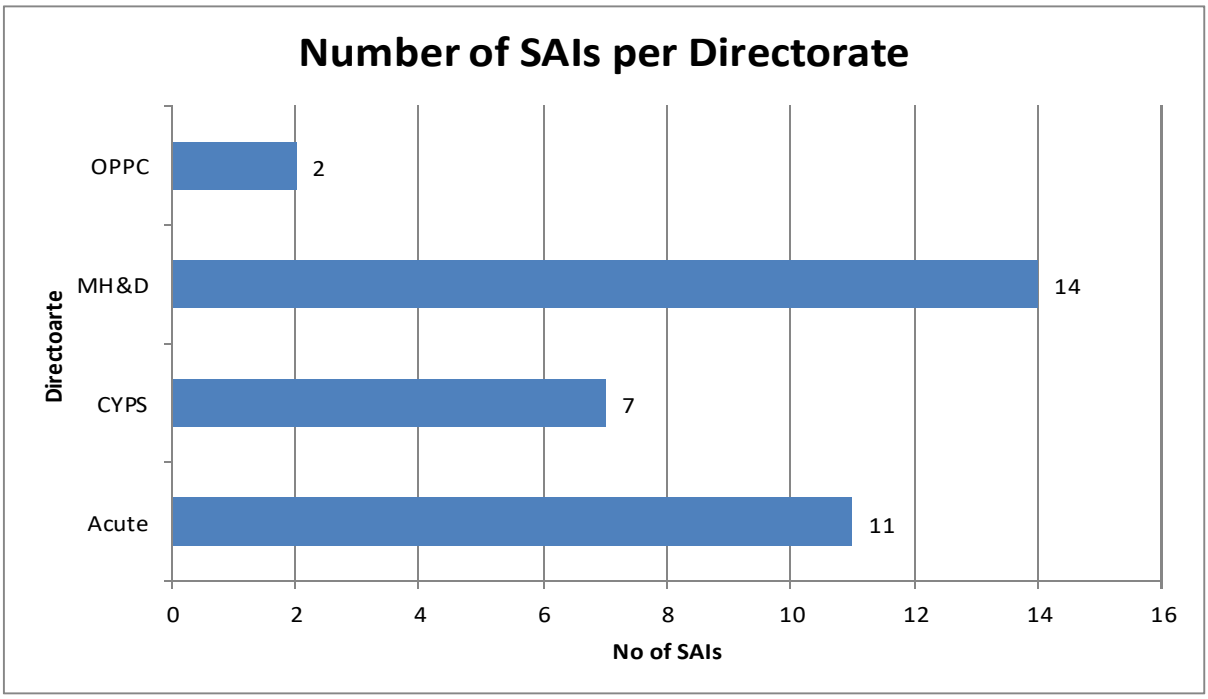
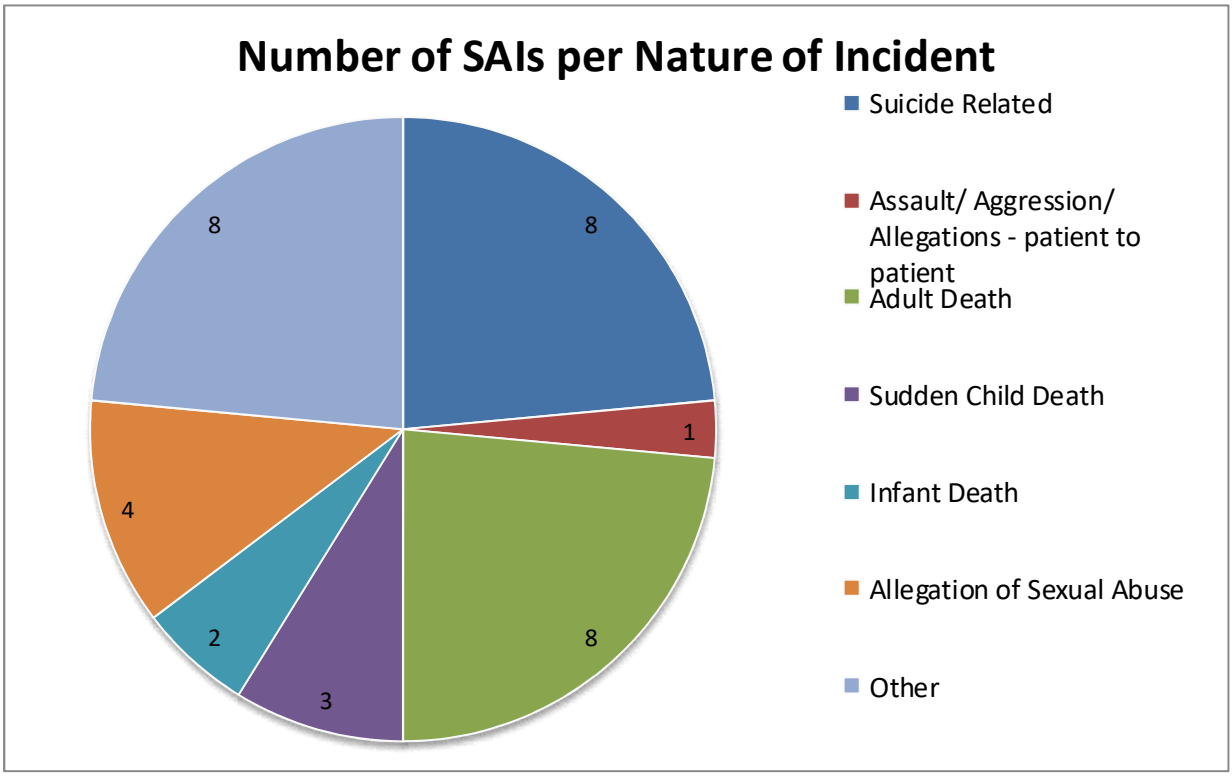


Figure 2 – Breakdown of total number of notified SAIs reported by Nature of Incident April – December 2011



SAI Overview of Initial Reports not yet submitted as at 24/01/2012

Overdue	
Due Soon	
Ready for release	
On Hold	

Incident No	Directorate	Nature Of Incident	Report Due	Status at 24/01/12
Personal Information redacted by the USI	CYPS	Inappropriately restraining of a Child	18/08/2011	Currently suspended as a PSNI Investigation takes place. Interim reports submitted to DRO.
	OPPC	Elderly Lady - Fall from 1st Floor Window	25/08/2011	Currently with D Burns for perusal before submission to SMT.
	CYPS	Allegation of Sexual Abuse	08/12/2011	Currently suspended as a PSNI Investigation takes place. Interim reports submitted to DRO.
	ACUTE	Infant Death	11/11/2011	Submitted to Acute Directorate Clinical Governance Forum 13.01.12.
	ACUTE	Infant Death	11/11/2011 **Ext granted 27/01/12**	Report in draft and circulated to Review Team for accuracy and comment.
	MHD	Suspicion of alleged Homicide	23/12/2011	Currently suspended as a PSNI Investigation takes place.
	ACUTE	Patient death following emergency surgery	30/12/2011	Report in Draft. Discussed at Acute Clinical Governance Forum and is for further amendments. Further extension requested 16.01.12.
	CYPS	Child Death	30/12/2011 **Ext granted 30/03/12**	Extension granted due to complexity of case as agreed per L Shaw (DRO) & D Burns. SHSCT will continue to chair & Board to bring in Acute DRO to assist L Shaw.
	ACUTE	Recording Error	30/01/2012 **Ext 10/02/12**	Extension requested for preparation of report on 16.01.12.
	MHD	Suspected Suicide (Hanging)	25/01/2012	Currently with D Burns for perusal before submission to SMT.
	ACUTE	Intra Hospital Transfer	25/01/2012 **Ext 15/02/12**	Meeting arranged with NIAMB with Chair of Review Team and M.Marshall.
	ACUTE	Unnecessary Scans	26/01/2012	Report circulated to Review team for accuracy and approval.
	MH&D	Suspected Suicide	20/02/2012	
	MH&D	Unexpected/Unexplained death of Personal Information redacted by male	07/03/2012	
	MH&D	Allegation of Rape.	09/04/2012	

SAI Overview of Initial Reports not yet submitted as at 24/01/2012

Incident No	Directorate	Nature Of Incident	Report Due	Status at 24/01/12
Personal Information redacted by the USI	MH&D	Suspected Suicide Personal Information redacted by old female	12/04/2012	
	Acute	Patient discharged from DHH, found dead at home	19/01/2012	
	MH&D	Suspected suicide of a Personal Information redacted by the USI old female	24/04/2012	

Stinson, Emma M

From: Burns, Deborah <Personal Information redacted by the USI>
Sent: 22 January 2014 21:12
To: Corrigan, Martina; Glenny, Sharon
Cc: Trouton, Heather; Stinson, Emma M
Subject: FW: 22.1.14 Cancer performance update
Attachments: 22.1.14 Cancer performance update.odt

Hi I would like to discuss each of these patients and their plan please – can you slot in Friday or tomorrow pm

Debbie Burns
Interim Director of Acute Services
SHSCT
Tel: Personal Information redacted by the USI
Email: Personal Information redacted by the USI

From: Clayton, Wendy
Sent: 22 January 2014 16:01
To: Carroll, Ronan; Reddick, Fiona; Muldrew, Angela; Lappin, Lynn; Trouton, Heather; Nelson, Amie; Glenny, Sharon; Carroll, Kay; Gibson, Simon; Richardson, Phyllis; McVey, Anne; McStay, Patricia; McAreavey, Lisa
Cc: Burns, Deborah
Subject: 22.1.14 Cancer performance update

Dear all

Please find attached this week's cancer performance summary.

Regards

Wendy Clayton
Operational Support Lead
Cancer & Clinical Services / ATICs
Southern Trust

Tel: Personal Information redacted by the USI
Mob: Personal Information redacted by the USI

CANCER (as at 22/1/14)

Breast 2ww performance

Week ending	0-14 Days	Within 14 Days %	15 Days+	Total
03/01/2014	9	34.6%	17	26
10/01/2014	15	30.6%	34	49
17/01/2014	43	84.3%	8	51

Dec 13 performance to date

- **62D = 84%; 31D = 100%;**
- 62D internal breacher – 6x Urology
- 62D external breach – 1x ENT (**ITT D53: FDT D155))** , 1x Skin (**ITT D10 to Ulster, back D48 for biopsy, ITT back to Ulster D72; FDT D113)**

62+D PTL

8 patients over 62+D

- 1 is now medically suspended due to high INR

- 1 closed no cancer

- 6 active

- 3 of the 6 active patients are over 85+D

Hospitalnumber	Tumour Site	Currentwait	Targetdate	Comment
Personal Information redacted by the USI	Urological Cancer	137	07/11/2013	**Surgery planned for 22/1/14, however cancelled as INR too high. Patient has been medically suspended.**
	Urological Cancer	131	13/11/2013	MRI performed and has been scheduled for MDM discussion on 23.01.14 with results - confirmed cancer
	Urological Cancer	89	25/12/2013	Update from Mr O'Brien- MRI appointed for 20.01.14. For MDM discussion on 23.01.13 with results. For review by Mr O'Brien @ SWAH on 27.01.14. Appearances are entirely consistent with an oncocytoma, but a low grade renal cell carcinoma cannot be excluded.
	Urological Cancer	82	01/01/2014	16/01/2014 Patient scheduled for partial nephrectomy for 04.02.14, D96. February breach
	Urological Cancer	82	01/01/2014	Review appointment offered 27/1/14 with Mr Gackin D87 & BCH appointment 29/1/14

Personal Information redacted by the USI	Urological Cancer	68	15/01/2014	Review with Mr Suresh - 23.01.14 - To request staging. Now on D67.
	Urological Cancer	67	16/01/2014	Date to be defined for left radical nephrectomy. Now on D63. Sharon to confirm date asap
	Urological Cancer	63	20/01/2014	**CLOSED AS NO CANCER**

ITT

25 active patients have been ITT'd

16 over 28D (64%) – spreadsheet attached in email with further information

- Gynae – D34, D43
- Haem – D36
- ENT D32, D54
- LGI – D37, D37, D42
- Lung – D35, D36, D42, D50
- Skin – D48, D48, D72
- UGI – D43

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REPORT SUMMARY SHEET

Meeting: **Date:**	**TRUST BOARD** **26 March 2015**
Title:	**Monthly Performance Management Report**
Lead Director:	**Paula Clarke, Director of Performance and Reform**
Corporate Objective:	• Provide safe high quality care • Maximise independence and choice for our patient and clients • Support people and communities to live healthy lives and to improve their health and wellbeing. • Make best use of resources.
Purpose:	**For Approval**
Summary of Key Areas:	***High level context:*** This report reviews performance at the end of February 2015 against the Commissioning Plan standards and targets and provides an assessment of current performance. The report highlights a number of areas of risk predominantly with respect to elective access standards.
Summary of Key Areas: (continued)	***Key issues/risks for discussion:*** • **Elective Access** –The Trust continues to work to maintain the access positions achieved at March 2014 (standards 9-weeks/13-weeks with maximum backstops of 15-weeks/26-weeks). As indicated in previous reports to the Trust Board performance against this target has become increasingly challenging, particularly in Acute Service Directorate, associated with the following key issues: o Decision taken in July by HSC to temporarily suspend sending any additional new patients to the Independent Sector (IS) for assessment or treatment and to temporarily 'pause' the treatment of a cohort of patients already in the IS; o Revised level of in-house additional capacity in Q1/2 resulting in greater gaps between demand and capacity; and o No confirmed funding for additional capacity in Q3/4(except for radiology). Whilst levels of activity continue to improve improving in line with the agreed Service & Budget Agreement (SBA), there are a number of specialty areas with capacity gaps where no allocation for additional activity in out-patients, in-patients and day cases has been provided by HSCB in Q3/4; this compounds

the backlog accrued in Q1/2 and will result in increased access times at March 2015.

The HSCB has confirmed a small allocation of funding for additional capacity in diagnostic imaging and endoscopy but this is insufficient in most areas to achieve the target access position.

- The Trust has updated its access times projected to be achieved at the end of March (Appendix 2).

    - Out-Patients – 18 out of 24 specialties monitored are in excess of the 15-week backstop. Of the 18, 11 specialties are over SBA; 6 of the18 specialties are under SBA with 4 out of the 6 within the <-5% tolerance. The remaining 2 out of the 6 are in excess of -10%.
    - In-Patients/Day Cases – 7 out of 13 specialties monitored are in excess of the 26-week backstop. Of the 7, 3 specialties are over SBA; 4 of the 7 specialties are under SBA with 2 out of the 4 within the <-5% tolerance. The remaining 2 out of the 4 are between >-5% and <-10%.
    - Diagnostics – 7 out of 8 specialties monitored are in excess of the 9-week access target. Of the 7 areas 6 have an aligned SBA; 5 of these are performing above SBA and one is under SBA at -3.51% but within the <-5% tolerance;
    - Mental Health – 2 out of 5 specialties monitored are in excess of the 9-week access target with 1 out of 2 specialty in excess of the 13-week access target; and
    - Allied Health Professionals – 5 out of 6 professions monitored are in excess of the 9-week access target.

    Other key risks affecting performance remain, relating to a number of common factors:

    - Recurrent investment has not yet been secured for all services with a recognised capacity gap. This, associated with current HSCB review of the level of funding available in-year for implementation of agreed investments, has affected the implementation and roll out of projects where funding has been agreed;
    - The impact of workforce controls relevant to Trust financial contingency plans;
    - Particular issues relating to sickness, maternity and other absences in the medical workforce and associated challenges in securing backfill capacity in general;
    - Continued pressures on demand in some areas including non-elective demand, urgent and red flag referrals; and
    - The need to allocate appropriate levels of capacity for service areas not subject to regional standards/targets eg. review appointments and planned repeat procedures.

- **Progress on prioritised recurrent Elective Investments –**
    - Initial areas prioritised for investment included ENT, Gynaecology, General Surgery, Cardiology, Rheumatology,

Endoscopy and Orthopaedics;
- Agreement has now been reached with HSCB for investment into ENT, T&O, General Surgery; Rheumatology and Gynaecology;
- Whilst an IPT had been submitted for Cardiology, this is now being revised, in light of revised service provision requirements. A high level proposal has also been submitted for in-year endoscopy investment for which formal response is awaited; and
- The Trust is working to implement in-year plans for areas where agreement has been secured.

- **Emergency Department** – The Trust continues to focus on effecting improvement and sustainability in performance against the ED Target and has dedicated senior staff to provide a focus on service improvement in ED and on patient flow throughout the hospital system.

  A high volume of attendances and the % of admissions via ED experienced in December has continued throughout January, February and into early March.

- **Cancer Pathways** – Whilst the Trust has experienced increased demand for cancer (red flag) referrals, which has affected performance against the 62-day pathway, the Trust continues to improve this position and achieved 91% in January, with an unvalidated position indicating February performance remaining relatively static. Regional focus has been on ensuring there are no patients waiting over 85 days. Within the Trust 0 patients waited over 85 days for definitive treatment at the end of January or February.

  In respect of the 14-day breast cancer performance the Trust has maintained its increased performance. Additional capacity, temporarily funded by the Trust, to focus on routine waits has seen the access time for routine patients decrease to 13-weeks at the end of February with an anticipated access time of 9-weeks at the end of March, assuming demand remains static.

- **AHP** –The Trusts internal review of AHP has identified a number of areas for improvement, including workforce, performance and professional best practice.

  Key performance challenges relate to demand and capacity in paediatric areas and performance against access standards continues to reflect longer waits. The Trust has sought engagement with HSCB/PHA to agree capacity and demand issues and establish a SBA for this service area. In addition, waits beyond the clinically indicated date have occurred for review and treatment in a number of AHP areas. The Trust has provided additional temporary support to address these backlogs and actions are in place to secure an improvement in this area.

	The Trust has engaged with staff side and key AHP representatives to discuss terms for a workforce review of skill and band mix to ensure the profile of staffing is consistent with the needs of the service. • **Mental Health Access –** Areas reported under mental health targets which continue to be challenged in the achievement of maximum waiting time targets are the Memory/Dementia service and Psychological Therapy service. In addition emergent issues are impacting in Primary Mental Health Care services which will see an increase in access times beyond the 9-week target. • **Memory/Dementia Service** –The Trust in conjunction with HSCB and SLCG has reviewed this service area in light of the current performance issues across the pathway. New agreed reporting arrangements have been implemented from the end of January. Whilst the SHSCT has the majority of breaches within the Region, for this target, it is progressing a demand and capacity analysis to define capacity gaps. This work will link into the implementation of the Regional Dementia Strategy. • **Primary Mental Health Care** – Demand and capacity issues are both impacting on PMHC. The service has seen an increase in referrals and an increase in the volume of urgent cases within this cohort. In addition there are challenges with capacity associated with staff sickness/absence. Whilst interim plans in place it is anticipated these plans will not be able to stem the increasing access times. The Commissioner has been advised of the issue. • **Psychological Therapies** – Due to medical staffing vacancies access times with Psychological Therapies have been affected. The service has attempted to secure temporary staff and additional in-house capacity without success. Permanent recruitment has been successful with staff commencing in Quarter 4. ***Summary of SMT challenge/discussion*** • Review of the reduced performance position at the end of Quarter 3 2014 to challenge potential for improvement particularly in the delivered SBA levels agreed to secure improvement for SBA performance. • Discussion of emerging risks within the clinical pathway and re-direction of temporary internal resources to address key areas of emerging clinical risk with noting on the corporate risk register. • Discussion re need for continued re-direction of temporary internal resources to address key areas of emergency clinical risk into April 2015. • Agreement to give priority to addressing patients waiting beyond their clinically indicated review timeline and acceptance that this

	may impact further on access for new patients but this risk to be balanced specialty by specialty. • Assurance sought on adherence to the IEAP in particular strict chronological management and DNA/CNA practices. • Agreement to continue targeting of senior capacity to support improvement in a number of high risk specialties/services with initial focus in ED/unscheduled care, AHP & Memory services.

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PERFORMANCE MANAGEMENT REPORT

COMMISSIONING PLAN STANDARDS/TARGETS FOR 2014/2015

INCLUDING INDICATORS OF PERFORMANCE

March 2015 Report for

February 2015 Performance

CONTENT

1.0 CONTEXT

This report forms part of the Trust's Performance Management Framework and sets out a summary of Trust performance for 2014/2015 against:

- Health and Social Care Commissioning Plan Standards/Targets

A significant number of Indicators of Performance (IoP) have been identified to complement the Commissioning Plan Standards and Targets. These IoPs whilst not identified as specific targets will be monitored in year to assess broader performance. Detailed in the attached report are the Indicators of Performance that are currently reported on a monthly basis.

2.0 REPORTING

Qualitative and quantitative updates on performance against the Commissioning Plan Standards/Targets are presented in this performance report under the themes of Ministerial Priority:

- To improve and protect health and well-being and reduce inequalities; through a focus on prevention, health promotion, anticipation and earlier intervention;
- To improve the quality of services and outcomes for patients, clients and carers through the provision of timely, safe, resilient and sustainable services in the most appropriate setting;
- To improve the management of long-term conditions in the community, with a view to improving the quality of care provided and reducing the incidence of acute hospital admissions for patients with one or more long-term conditions;
- To promote social inclusion, choice, control, support and independence for people living in the community, especially older people and those individuals and their families living with disabilities;
- To improve the productivity by ensuring effective and efficient allocation and utilisation of all available resources, in line with priorities;
- To ensure the most vulnerable in our society, including children and adults at risk of harm are looked after effectively across all our services;

The level of performance, based on the current and anticipated progress, will be assessed as follows:

Green (G)	Standard/target achieved/on track for achievement – Monitor progress to ensure remains on track
Yellow (Y)	Standard/target substantially achieved/on track for substantial achievement – Management actions in place/monitor progress to ensure standard/target remains on track
Amber (A)	Standard partially achieved/limited progress towards achievement of target – Management actions required
Red (R)	Standard/target not achieved/not on track to achieve – Management actions/intervention required
	Not assessed (due to lack of baseline; target; or robust data)

The performance trend, representing the direction of progress during the financial year, will be indicated by the arrows below:

↑	Performance improving	↓	Performance decreasing	⇔	Performance static

3.0 COMMISSIONING PLAN STANDARDS/TARGETS AND ASSOCIATED PERFORMANCE

MINISTERIAL PRIORITY: TO IMPROVE THE QUALITY OF SERVICES AND OUTCOMES FOR PATIENTS, CLIENTS AND CARERS THROUGH THE PROVISION OF TIMELY, SAFE, RESILIENT AND SUSTAINABLE SERVICES IN THE MOST APPROPRIATE SETTING

CP 5: HIP FRACTURES: Lead Director Mrs Deborah Burns, Interim Director of Acute Services

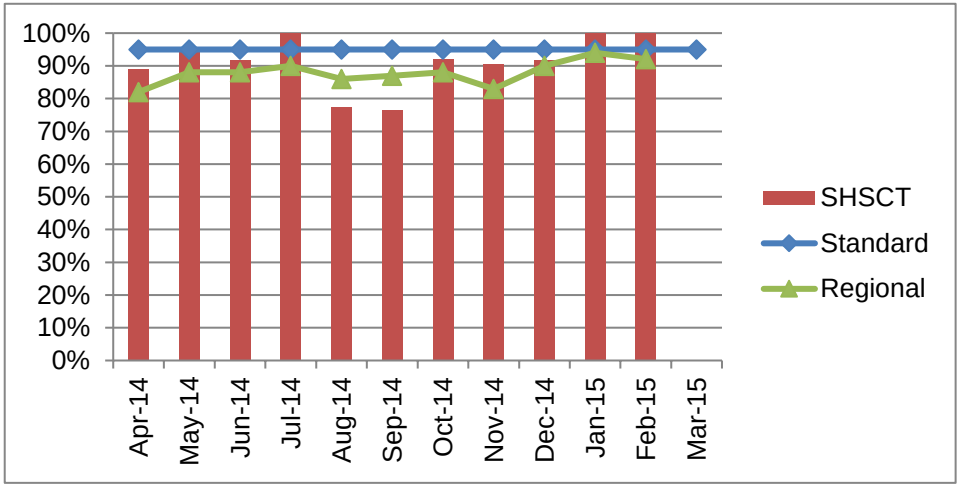
From April 2014, 95% of patients, where clinically appropriate, wait no longer than 48 hours for in-patient treatment for hip fractures.

Baseline: 91% (2013/2014) **TDP Assessment:** Likely to be achieved with some delay / partially achieved	**Standard:** 95%

Comments:

January performance varied across the Region from 78% (SEHSCT) to 100% (SHSCT and BHSCT).

On-going trauma pressures have resulted in the cancellation of elective orthopaedic surgery to facilitate the treatment of the clinically urgent trauma cases. From 1 April to week commencing 9 March 2015 103 elective orthopaedic operative cases have been cancelled to facilitate trauma cases. Whilst HSCB have confirmed in-year funding allocations for Trauma & Orthopaedic (T&O) implementation, this did not include funding to facilitate the re-provision of any cancelled orthopaedic cases which is affecting access times in this specialty. This has also lead to an underperformance on the service and budget level agreement by an estimated -6%.



Actions to Address:

- The Trust continues with the T&O in-year implementation plan. Consultant 1 and 2 are in post with consultant 3 commencing August 2015; with the recruitment process ongoing for the 4th Consultant.
- The Trust continues to work with the HSCB Director of

Commissioning to develop a 'blue-sky' model to address future service demand and is initiating pilot work in-year to enable this model with release of staff to commence nurse led fracture clinics, training of surgical theatre assistant and additional theatre capacity with specialty doctor working parallel to consultant staff; the impact of the initial work will be assessed by the commissioner in June. • On a daily basis the clinical team ie. Consultants; Junior Medical Staff; and Trauma Co-Ordinator meet, to present each trauma case, and agreed on the clinical priority of the cases and the trauma list for that day.	

Site	Monthly Position:												Cum. Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Trust	89.5% (17 out of 19)	95.5% (21 out of 22)	91.7% (22 out of 24)	100% (15 out of 15)	78.3% (17 out of 22)	76.5% (13 out of 17)	92% (23 out of 25)	90.5% (19 out of 21)	91.7% (33 out of 36)	100% (30 out of 30)	100% (26 out of 26)		**Y**	↑
Regional	82%	88%	88%	90%	86%	87%	88%	83%	90%	94%	92.1%			

CP 6: CANCER CARE SERVICES: Lead Director Mrs Deborah Burns, Interim Director of Acute Services

From April 2014, all urgent breast cancer referrals should be seen within 14-days.

Baseline: 73.9% (April to December 2013)
TDP Assessment: Likely to be achieved with some delay / partially achieved

Standard: 100%

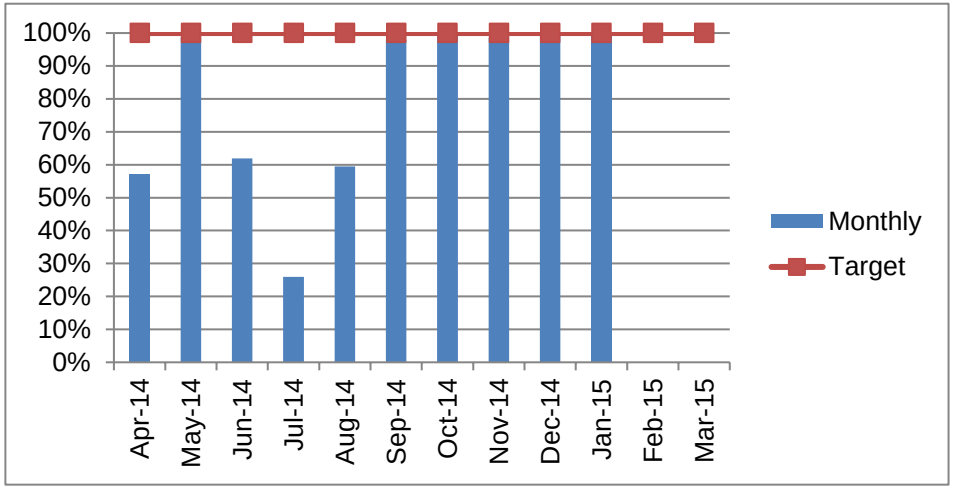
Comments: February update not available

January performance across the Region varied from 79% (BHSCT) to 100% (NHSCT; SEHSCT; and SHSCT).

Whilst routine waits had extended out to 24-weeks the service has now commenced additionality through internal funding and has achieved, as per the plan, 13-weeks at the end of February and continues to work to 9-weeks for March, assuming demand remains static.

Actions to Address:

- Additional clinics continue to be undertaken in Quarter 4, facilitated through internal funding which will continue to improve access times for routine patients. continue to provide interim funding for this capacity gap
- The Trust has met with the SLCG and confirmed recurrent capacity gap for Symptomatic Breast services. An investment proposal is being prepared.



Monthly Position:												Cum. Assess	Trend
Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**		
57.3% (110 out of 192)	98.7% (154 out of 156)	61.9% (112 out of 181)	25.9% (65 out of 251)	59.5% (115 out of 284)	98% (244 out of 248)	100% (233 out of 233)	98.6% (218 out of 221)	100% (249 out of 249)	99.5% (221 out of 222)	No update		Y	↑

CP 6: CANCER CARE SERVICES: Lead Director Mrs Deborah Burns, Interim Director of Acute Services

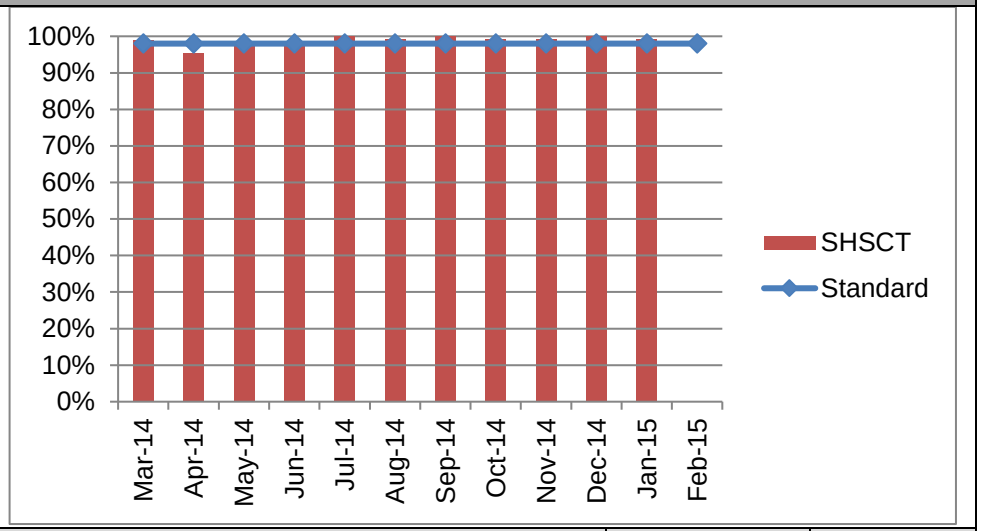
From April 2014, at least 98% of patients diagnosed with cancer should receive their first definitive treatment within 31-days of a decision to treat.

Baseline: 99.3% (April to December 2013)
TDP Assessment: Likely to be achieved with some delay / partially achieved

Standard: 98%

Comments: Reporting one month in arrears.
Performance against the 31-day standard is based on completed waits ie. those patients that have had their cancer confirmed and who have received their first definitive treatment.

January performance across the Region remained relatively static with it ranging from 89% (BHSCT) to 100% (SHSCT and WHSCT).



Monthly Position:												Cum Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
95.45%	97.75%	98.43%	100%	99.06%	100%	99.2%	99.07%	100%	99.16%			Y	↑

CP 6: CANCER CARE SERVICES: Lead Director Mrs Deborah Burns, Interim Director of Acute Services

From April 2014, at least 95% of patients urgently referred with a suspected cancer should begin their first definitive treatment within 62-days.

Baseline: 89.6% (April to December 2013)
TDP Assessment: Likely to be achieved with some delay / partially achieved

Standard: 95%

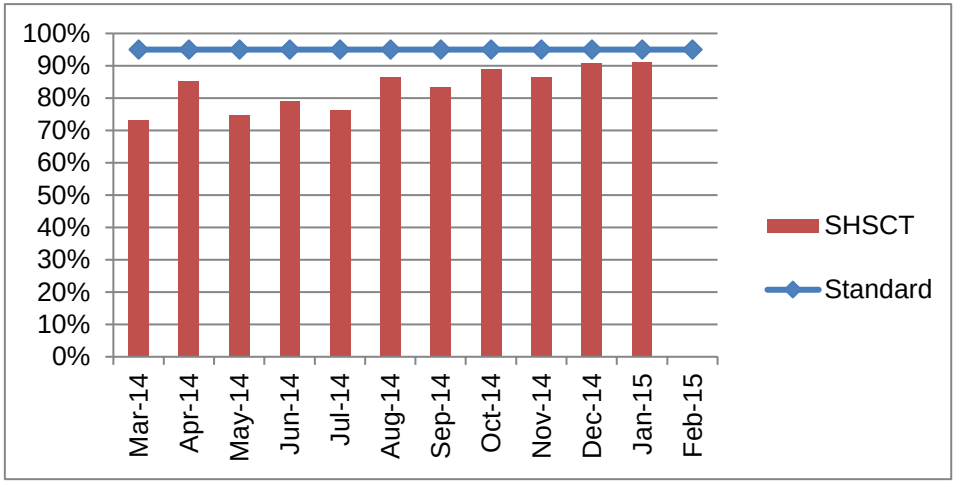
Comments: Reporting two months in arrears.
Performance against the 62-day standard is based on completed waits ie. those patients that have had their cancer confirmed and who have received their first definitive treatment.

62-Day: In January there were 9 patients in excess of the 62-day standard: 1 Urology (Internal); 1 Head and Neck (External); 2 Lung (External) and 5 Urology (External).

Unvalidated February position is 88.3% with 9 patients in excess of the 62-day standard: 1 Haematology (External); 1 Lung (External); 2 Upper GI (External); 3 Urology (External); 1 Head and Neck (External) and 1 Skin (External).

Day-85: There were no breaches of Day 85 in January or February 2015.

January performance across the Region varied from 54% (SEHSCT) to 94% (WHSCT).



Monthly Position:												Cum Assess	Trend
Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
85.37%	74.73%	79.05%	76.23%	86.41%	83.33%	88.89%	86.3%	90.91%	91.07%			A	↑

Note: amendment to October / November data

CP 7: UNSCHEDULED CARE: Lead Director Mrs Deborah Burns, Interim Director of Acute Services	
From April 2014, 95% of patients attending any Type 1, 2 or 3 Emergency Department are either treated and discharged home, or admitted, within 4 hours of their arrival in the department.	
Baseline: Trust – 82.19% (2013/2014) CAH – 72.8% (2013/2014) DHH – 86.6% (2013/2014) **TDP Assessment:** Likely to be achieved with some delay / partially achieved	**Standard:** 95%

Comments:

Performance continues to be challenging and a range of initiatives have been implemented to improve this position. Patient flow continues to be a particular challenge over the Winter period and the Trust has experienced an unusually sustained period of bed pressures. The high level of attendances and admissions felt over the Christmas and New Year period has continued through, January, February and into March.

In January CAH ED experienced daily admissions from ED ranging from 42 – 64 per day with an average of 52. The average admissions per day in February further increased to 59 with the range from 48 – 74. In the first 11 days of March the average admissions remains static at 58 with the range from 47 – 68.

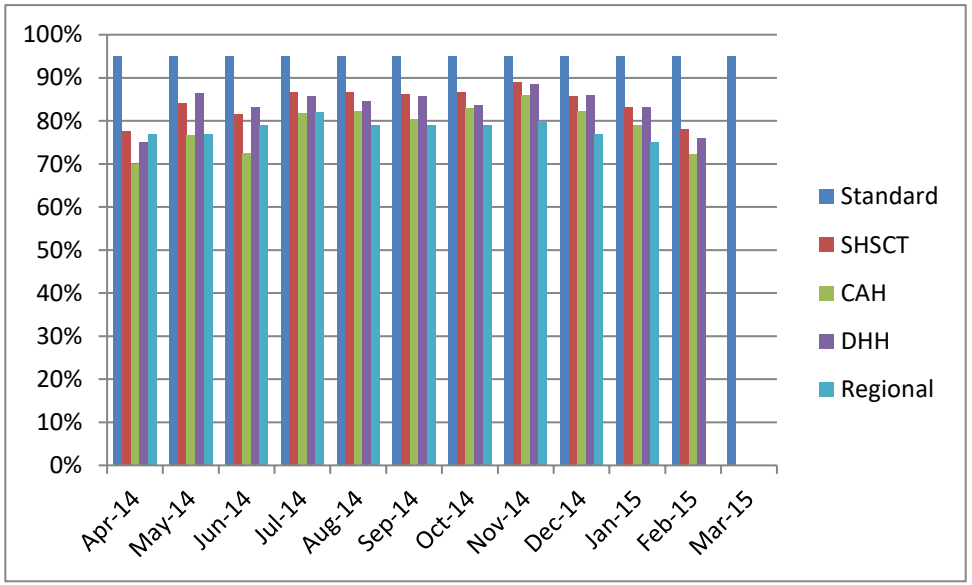
In February DHH ED experienced daily admissions from ED ranging from 13 to 37 with an average of 27. In the first 11 days of March the average admissions remains static at 25 with the range from 20 to 33.

Of note the Trust was the highest performing again in January across the Region with performance ranging from 66% (NHSCT) to 83% (SHSCT).

Graph 2 demonstrates the volume and percentage of admissions via ED, on the CAH site, from the period 21/12/14 to 11/3/15 with the % of admissions via ED, which averaged at 27%, peaking at 35%.

Actions to Address:

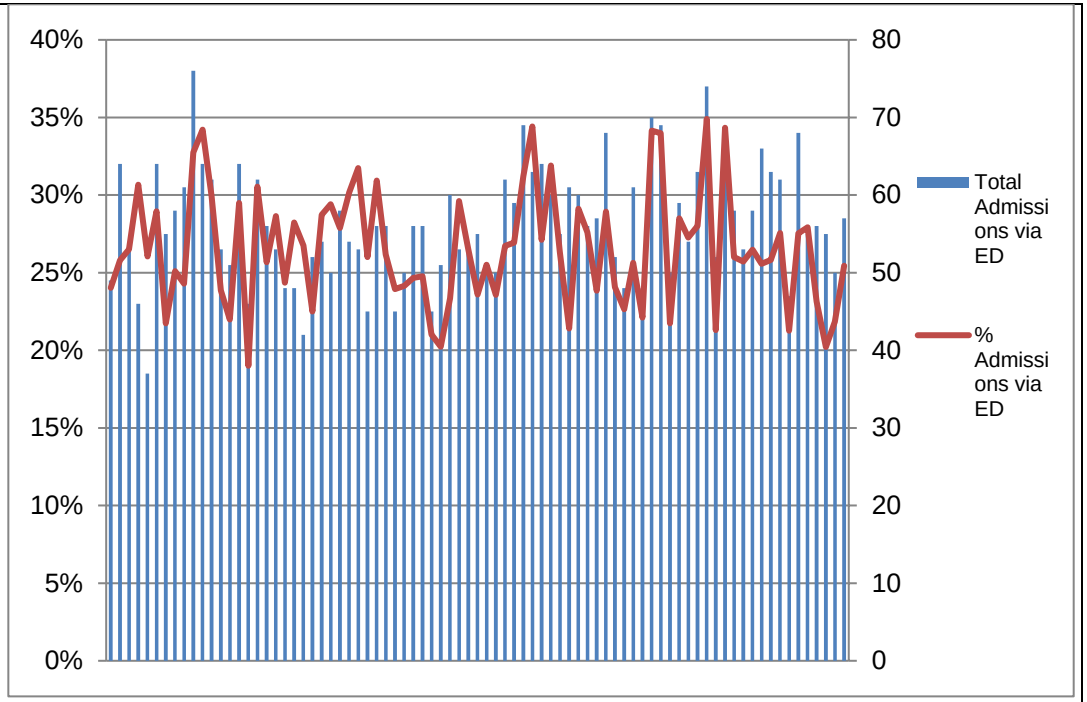
- Sustained management & clinical focus in and out of hours to maintain focus and support to staff during this prolonged period of



Graph 1 – 4-Hour Performance

Winter pressures

- Ongoing review of the '60 minute plan' to focus on triage, front loading investigation, streaming and early assessment and treatment to review practice and take appropriate actions to support this as appropriate. The improvements delivered through the implementation of the '60 minute plan' have been impacted upon with further pressure in the CAH ED due to medical staffing pressures – 2 vacant consultant posts (one due to be filled early May 2015 with the other relating to new long-term sick leave); and gaps at middle grade level, which the department have been unable to cover through agency;
- Improvement work focused on throughput in the minor stream, to ensure early assessment, prompt treatment post assessment and escalation to Band 6 clinical sister has been initiated and ED is working to a culture whereby 'no minor patients should breach;
- The daily patient flow processes in CAH have been amended with the objective of pulling discharges forward and working towards having the hospital settled by 8.00pm. This is to avoid a build-up of admissions in the ED in the evening which impact on the patient experience and cause longer waiting times. Monday - Friday calls continue with Alamac, assessing performance against the 4 hour standard and highlighting areas for further improvement.
- From April 2015 an Expeditor Role in CAH ED is to be introduced from 12 midday to 11.00pm, 7-days a week, for a period of 6-months, initially. This is to be progressed through existing resources; and
- The Trust is working with the Commissioner on an Unscheduled Care Plan to address 5 key areas (as identified by HSCB/PHA) and also the medical bed capacity problem in CAH.



Graph 2 – Number of Admissions and % of Admissions via CAH ED for the period 21/12/14 to 11/3/15

Site	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Trust 4-Hour	77.6% (10182 out of 13120)	84.2% (10882 out of 12922)	81.5% (11039 out of 13539)	86.7% (11537 out of 13309)	86.7% (10849 out of 12510)	86.1% (11240 out of 13052)	86.6% (10925 out of 12615)	89.1% (10517 out of 11797)	85.8% (10295 out of 11994)	83.3% (9751 out of 11699)	78% (8983 out of 11520)		R	↑
Trust 6-Hour	91.4% (11996 out of	96% (12406 out of	94.3% (12765 out of	96.2% (12808 out of	96.4% (12055 out of	95.7% (12487 out of	95.5% (12050 out of	96.7% (11408 out of	95.7% (11484 out of	94.1% (11011 out of	91.9% (10584 out of			↑

	13120)	12922)	13539)	13309)	12510)	13052)	12616)	11797)	11994)	11699)	11520)			
Site	**Monthly Position:**												**Cum Assess**	**Trend**
	Apr	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**		
CAH 4-Hour	70% (4588 out of 6553)	76.7% (4986 out of 6503)	72.6% (4838 out of 6665)	81.7% (5348 out of 6544)	82.3% (5004 out of 6078)	80.4% (5168 out of 6430)	83% (5268 out of 6349)	86% (5403 out of 6284)	82.2% (5462 out of 6645)	79% (5032 out of 6371)	72.2% (4408 out of 6103)		**R**	↑
CAH 6-Hour	88.4% (5794 out of 6553)	93.8% (6099 out of 6503)	91.2% (6077 out of 6665)	94.7% (6194 out of 6544)	95.1% (5778 out of 6078)	93.8% (6029 out of 6430)	93.7% (5947 out of 6349)	95.6% (6005 out of 6284)	94.5% (6281 out of 6645)	92.2% (5876 out of 6371)	89.9% (5486 out of 6103)			↑
DHH 4-Hour	75.1% (2934 out of 3907)	86.4% (3318 out of 3840)	83.1% (3298 out of 3971)	85.7% (3459 out of 4035)	84.5% (3209 out of 3796)	85.8% (3316 out of 3866)	83.7% (3111 out of 3719)	88.6% (3109 out of 3508)	86% (3174 out of 3689)	83.1% (2984out of 3593)	75.9% (2658 out of 3500)		**R**	↑
DHH 6-Hour	90.7% (3542 out of 3907)	97.1% (3728 out of 3840)	95.3% (3785 out of 3971)	96.3% (3884 out of 4035)	95.9% (3641 out of 3796)	95.8% (3702 out of 3866)	95.6% (3555 out of 3719)	96.9% (3398 out of 3508)	96.1% (3544 out of 3689)	94.6% (3400 out of 3593)	90.9% (3181 out of 3500)			↑
Regional Ave (Peer)	77%	77%	79%	82%	79%	79%	79%	80%	77%	75%	No update			

CP 7: UNSCHEDULED CARE: Lead Director Mrs Deborah Burns, Interim Director of Acute Services

From April 2014, no patient attending any Emergency Department should wait longer than 12 hours.

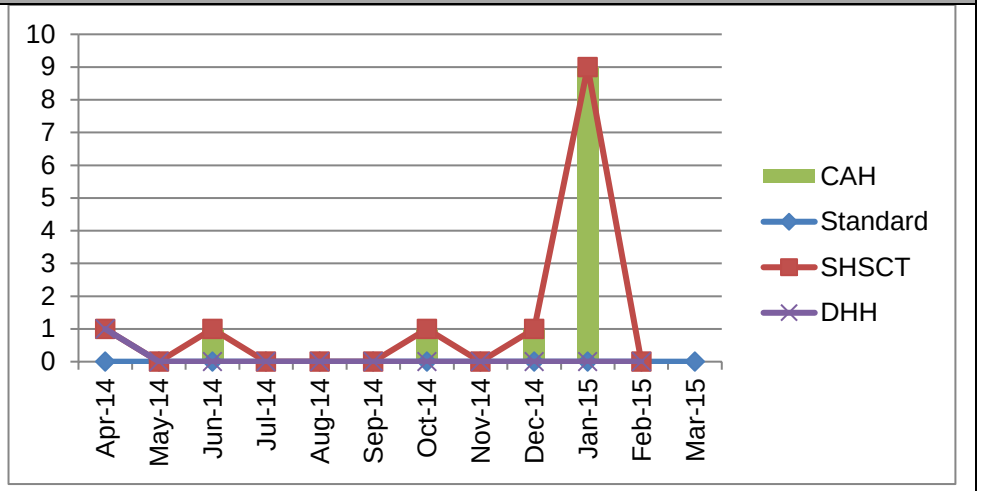
Baseline: 96 (2013/2014)
TDP Assessment: Likely to be achieved with some delay / partially achieved

Standard: 0

Comments:

There have been 9 further breaches of the 12-hour standard, on three consecutive days, in January when volumes of attendances and admissions remained high. Regionally pressures on EDs remained high in this period with 380 breaches, ranging from 7 (WHSCT) to 237 (SEHSCT).

From April to January 205 there was a total of 1919 breaches of the 12-hour standard in the Region, with SHSCT only accounting for 4 of these (0.7%).



Site	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
Trust	1	0	1	0	0	0	1	0	1	9	0		**R**	↓
CAH	0	0	1	0	0	0	1	0	1	9	0		**R**	↓
DHH	1	0	0	0	0	0	0	0	0	0	0		**G**	↔

GP OUT OF HOURS: Lead Director Mrs Angela McVeigh, Director of Older People & Primary Care

GP Out of Hours Standards are:
Urgent triage (UT) 90% within 20 minutes — Routine triage (RT) 90% within 60 minutes
Urgent face to face (UF2F) appointment 90% within 2-hours — Routine face to face (RF2F) appointment 90% within 6-hours

Comments:

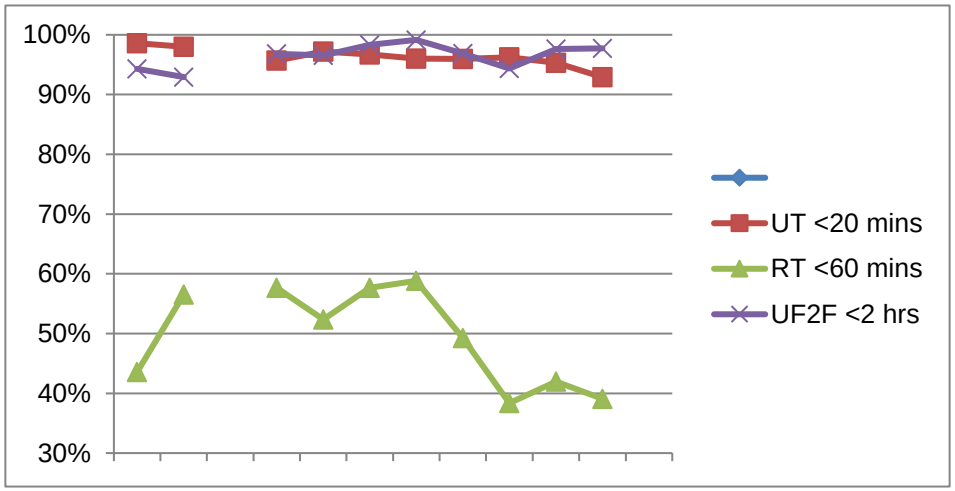
In order to reflect the totality of pressures on the 'unscheduled system' information on GP Out of Hours performance has been included. Whilst this is not a Commissioning Plan Standard or Indicator of Performance its activity / performance can have a direct relationship to ED.

- Urgent triage – of the 127 patients not triaged within 20-minutes, 7 patients waited in excess of 60 minutes for urgent triage.
- Routine triage – of the 3577 patient not triaged within 20-minutes, 167 patients waited 10 + hours for routine triage.
- Urgent face to face base attendance – of the 9 patients not seen within 2-hours, 1 patient waited 5-6 hours for an urgent face to face base appointment.
- Routine face to face base attendance – of the 78 patients not seen within 2-hours, 1 patient waited 16-18 hours for a routine face to face base appointment.

The ability to maintain adequate service provision and standards for triage relate to ongoing challenges presented in filling vacant GP shifts. Efforts to recruit additional GPs and Locum staff have not been successful.

Actions to Address:

- To supplement the current service, for triage, the Trust has recruited 30 nurses to undertake triage. The first cohort to staff are beginning their IT training in the middle of February and will follow with shadowing current staff. The second cohort of staff will begin training at the end of February.
- The Trust has also concluded interviews for Advanced Nurse Practitioners and 5 staff have accepted the posts and are awaiting their IT training.
- A pilot has been developed to enable Pharmacists to undertake triage, at weekends, for medication related calls. The recruitment process is completed and 9 applicants have been appointed and are attending Induction in mid-February. The staff will shadow the GPs for a period and then will begin shifts on Sunday, 1 March with shifts covering 11am



– 4pm Saturday; Sunday; and Bank Holidays. • Through additional funding secured for Winter Pressures additional GP shifts have been offered Monday – Thursday (4 hour shift); Friday (5 hour shift); Saturday and Sunday (20 hours in 4 shifts), with over 50% uptake on these shifts. • Trust is exploring pilot of enabling IT equipment to support Out of Hours processes.	

	Monthly Position:												Cum Assess	Trend
	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar		
UT <20 mins	98.6%	97.99%	No Update	95.67%	97.19%	96.7%	96.04%	95.95%	96.21%	95.31%	92.91%		G	↓
No. >20 mins	23	30		52	35	36	50	64	75	92	127			↓
RT <60 mins	43.57%	56.53%		57.69%	52.34%	57.67%	58.83%	49.28%	38.36%	41.99%	39.09%		R	⇔
No. >60 mins	4391	3514		2576	2913	2293	2309	3296	4498	3839	3577			⇔
UF2F <2 hrs	94.28%	92.93%		96.83%	96.55%	98.34%	99.15%	96.89%	94.36%	97.6%	97.74%		G	↑
No. >2 hrs	31	36		11	10	5	3	14	26	10	9			↑
RF2F <6 hrs	98.38%	98.18%		98.73%	98.20%	98.69%	98.48%	98.97%	96.86%	97.38%	96.98%		G	⇔
No. >6 hrs	45	49		35	43	34	43	34	107	80	78			↓

CP 9: HOSPITAL RE-ADMISSIONS: Lead Director Mrs Deborah Burns, Interim Director of Acute Services

By March 2015, secure a 5% reduction in the number of emergency re-admissions within 30 days (using the 2012/2013 data as the baseline).

Baseline: To be confirmed
TDP Assessment: To be confirmed

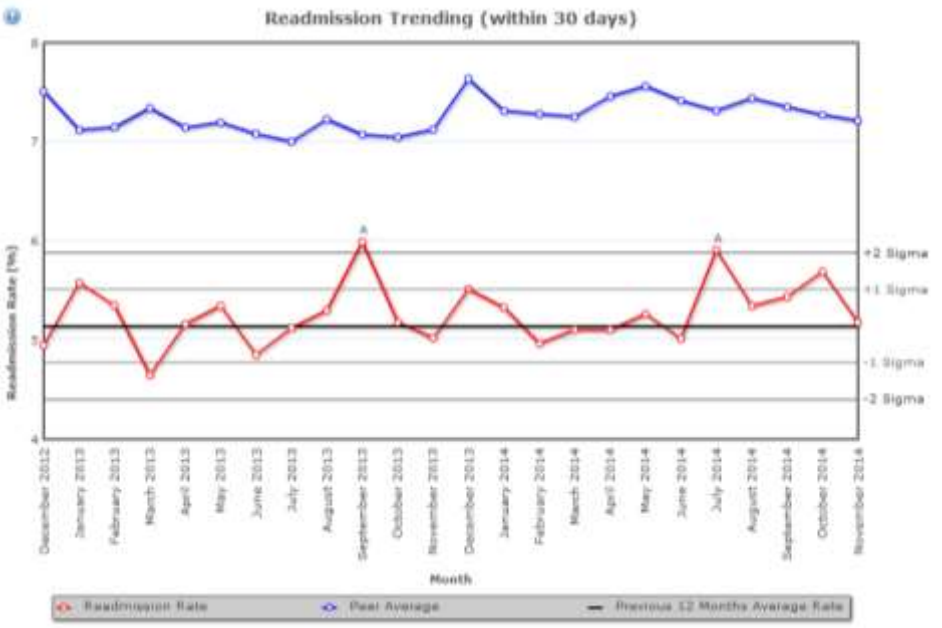
Target: 5% reduction

Comments: Reporting three months in arrears.
Based on April to October 2014 data provided by the HSCB, demonstrates a re-admission rate of 14% for the SHSCT against the baseline position of 2012/2013. Performance across the Region varies from 14% (SHSCT) to 55% (BHSCT).

CHKS, the comparative benchmarking system, measures re-admissions against the top hospital peers. Whilst this definition and the comparators are slightly different from those used by HSCB this is a useful guide to performance against our peers and in providing assurance regarding appropriate patient care. CHKS indicates the Trusts re-admission rate at 5.4% (April – November 2014) which is below the peer average of 7.4%.

The chart demonstrates the average % of re-admissions for the SHSCT over the last two years (December 2012 to November 2014) against the mean position for the previous 12 months. This red line shows some variability however it is significantly below the peer average performance which is represented by the blue line.

A detailed analysis of re-admissions has been undertaken which identifies that whilst the level of re-admissions in CAH is slightly higher than in DHH the collective position across the Trust is still lower than the Top Hospital peer group. Analysis by the top 10 condition groups, which represent 30% of total re-admissions to the Trust, indicates the Trust is below the Top Hospital peer for all areas; which provides assurance.



Monthly Position:													Cum Assess	Trend
Target	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**		
Cumulative Position	2658													
Target Position	2335													

Variance Against Baseline	+14% (+324)						**R**	

Note: Data sourced from Regional HSCB Board Performance Report

CP 10: ELECTIVE CARE OUT-PATIENTS: Lead Director Mrs Deborah Burns, Interim Director of Acute Services	
From April 2014, at least 80% of patients wait no longer than 9-weeks for their first out-patient appointment and no patient waits longer than 15-weeks.	
Baseline: 79.43% <9-weeks (2013/2014) 1454 >15-weeks (@ 31 March 2014) **TDP Assessment:** Achievable, dependent upon additional funding being available	**Standard:** 80% <9-weeks 0 >15-weeks
Comments: Regionally, January average performance against the % waiting less than 9-weeks was 46% with performance varying from 35% (BHSCT) to 53% (WHSCT). The total waiting in excess of 15-weeks regionally was 69,428 with SHSCT accounting for 13% of these patients. At the end of February the following specialties were in excess of the maximum backstop of 15 weeks: • Dermatology (inc ICATS) – 1688 patients, longest wait 40-weeks; *(SBA underperforming)* • Urology (inc ICATS) – 1020 patients, longest wait 53-weeks *(SBA underperforming)* • Ortho-Geriatrics – 41 patients, longest wait 46-weeks; *(SBA over performing)* • Neurology – 450 patients, longest wait 29-weeks; *(SBA underperforming)* • Orthopaedic (Consultant Led), 770 patients – longest wait 36-weeks; *(SBA underperforming)* • Cardiology (Consultant Led) – 470 patients, longest wait 31-weeks*(SBA over performing)* • Orthopaedic ICATS – 445 patients, longest wait 42-weeks (1 patient waiting 42 weeks booked in month – next longest wait is 28-weeks); *(SBA over performing)* • ENT (Consultant Led) – 672 patients, waiting 25-weeks; *(SBA over performing)* • General Surgery – 261 patients, longest wait 21-weeks; *(SBA underperforming)*